Philippines

Contraceptive Logistics System

Review of Accomplishments and Lessons Learned (1991–1997)

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FPLM

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The Family Planning Logistics Management (FPLM) project is funded by the Office of Population of the Bureau for Global Programs, Field Support and Research of the U.S. Agency for International Development (USAID). The agency's Contraceptives and Logistics Management Division provides a centralized system for contraceptive procurement, maintains a database on commodity assistance, and supports a program for contraceptive logistics management.

Implemented by John Snow, Inc. (JSI) (contract no. CCP-C-00-95-00028-00), and subcontractors (The Futures Group International and the Program for Appropriate Technology in Health [PATH]), the FPLM project works to ensure the continuous supply of high-quality health and family planning products in developing countries. FPLM also provides technical management and analysis of two USAID databases, the contraceptive procurement and shipping database (NEWVERN); and the Population, Health, and Nutrition Projects Database (PPD).

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Abstract

This report describes the technical assistance strategy employed by the FPLM project to assist the Philippines Department of Health in developing a contraceptive logistics management system. A study of the system was conducted in December 1997, after seven years of assistance, to assess the progress achieved and to extract lessons learned that may be applicable in other countries. Recommendations are also suggested for future work in the Philippines.

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Acronyms

AMU	average monthly use
ASL	authorized stock level
BHS	barangay health station
CARE	Cooperative for Assistance and Relief Everywhere
CCMIS	Contraceptive Commodity Management Information System
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CDMS	Contraceptive Delivery Monitoring System
CDOS	Contraceptive Delivery Order System
COF	contraceptive order form
CPT	contraceptive procurement table
CSEP	Country Strategic and Evaluation Plan
CSW	commercial sex worker
DHO	district health office
DOH	Department of Health
EDD	Essential Drugs Distribution
FPLM	Family Planning Logistics Management project
FPPO	family planning program officer
FPS	Family Planning Service
HMDIS	Health Manpower Development and Training Service
LCE	local chief executive
LGAMS	Local Government Assistance and Monitoring Service
LGEDDS	Local Government Essential Drugs Distribution System
LGU	local government unit
LHB	local health board
LMIS	logistics management information system
LPP	Local Government Unit Performance-Based Program
MAS	Management Advisory Service
MHC	main health center
MIS	management information system
MOA	memorandum of agreement
MOU	memorandum of understanding
NCR	National Capital Region
NGO	nongovernmental organization
PFPP	Philippine Family Planning Program
PHO	provincial health office
PLS	Procurement and Logistics Service
POPCOM	Commission on Population
RHO	regional health office
RHU	rural health unit
RIV	requisition and issue voucher
SDP	service delivery point
SDR	summary delivery report
SOH	stock on hand
USAID	United States Agency for International Development
WHO	World Health Organization
WHSM	Women's Health and Safe Motherhood project, World Bank

Preface

This paper contains a status report on the Family Planning Logistics Management project funded by the United States Agency for International Development, which has provided technical assistance to the Philippines Family Planning Program in developing a countrywide contraceptive logistics system. The study took place in December 1997, 12 months before the anticipated withdrawal of technical assistance and assesses technical assistance provided by the Family Planning Logistics Management project from 1991 through 1997. The study was conducted by the Philippines Department of Health and the Family Planning Logistics Management project based in Arlington, Virginia.

With several more months of project operations ahead and an impending initiative to bring a number of essential drugs into the contraceptive logistics system, it was an opportune time to conduct an interim internal assessment of the technical assistance provided by the Family Planning Logistics Management project.

The study involved the collection of qualitative data through key informant interviews and a qualitative analysis of the logistics system using the Composite Indicators for Contraceptive Logistics Management as planned under the Family Planning Logistics Management project's Country Strategic and Evaluation Plan for the Philippines. Included in this report are the study objectives, study method, study results, and general findings; an examination of the design and implementation of the logistics effort and the setting in which it took place; lessons learned; and recommendations that can provide guidance to other organizations concerned about health sector logistics.

The authors wish to acknowledge the contributions of Dave Alt, Chief of Party, FPLM/Philippines, whose knowledge, guidance and support during this assessment was critical. The guidance of FPLM/Philippines logistics advisors during the field visits, particularly Ray Frogoso and Miriam Balahadia, and their intimate knowledge of the system were invaluable. We value the cooperation, shared perceptions and comments of government and nongovernmental staff of all organizations contacted during this process, and all the people of the Philippines who were interviewed as part of the assessment. In addition, we are grateful for the efficient support and administrative facilitation of FPLM/Philippines Secretary Elvira "Baby" Santos, who organized the program for field trips and key informant interviews so diligently. Thanks also to the drivers, administrative and ancillary staff of FPLM/Philippines who were helpful in facilitating the smooth running of this assessment.

Finally, we appreciate the contributions made by FPLM/Washington staff, particularly Dana Gelfeld who reworked, contributed to, and edited the final report for publication, and to other senior staff who reviewed the report for technical content.

Executive Summary

The Family Planning Logistics Management project has worked with the Philippine Department of Health in designing, implementing and institutionalizing an efficient contraceptive logistics system through resident technical assistance since 1991. During this time, a successful pilot project was also implemented to incorporate a limited number of essential drugs into the contraceptive logistics management information system. This paper presents the study findings, lessons learned and recommendations for future improvements in the system and for achieving institutionalization based on the study conducted in December 1997.

The Philippines Family Planning Program faces many challenges in institutionalizing their contraceptive logistics system. Attempts to outsource regional distribution of contraceptives to a private freight forwarding company faced many difficulties, especially complicated contracting procedures which repeatedly resulted in delayed shipments.

Furthermore, delays in filling critical central level logistics positions at the Department of Health has stalled full institutionalization of the system. Recent decentralization policies, resulting in the transfer of central level staff, has left the Philippine Logistics Services without enough staff to maintain basic logistics functions at the central level.

The findings of this study have highlighted several lessons learned from the technical assistance provided, for example:

- Running a system as a distinct project with full external funding, a long-term resident advisor, and dedicated local staff is less complicated than institutionalizing it into a government agency.
- Spreading responsibility for the same function across two or more government offices causes confusion in the field and makes the work of the technical assistance team more difficult.
- A logistics section with dedicated full-time staff within the health ministry must take charge of the logistics system if sustainability is to be achieved.
- Health workers at the regional level must receive high quality, face-to-face training to motivate and equip them with the skills they need to perform their roles in the system and ensure sustainability of the contraceptive logistics program.
- Constant monitoring of the system maintains an efficient and strong logistics management information system.
- An efficient logistics management information system can encourage the integration of drug supplies.

In addition, among the recommendations resulting from this study were the following:

- Central-level staff should be formally trained in logistics management during 1998 through the Family Planning Logistics Management project's international training in Arlington, Virginia.
- Family Planning Logistics Management/Philippines should hire two temporary data encoders to help clear the data entry backlogs.

- Management Advisory Service should assign a technical backstopper to the logistics management information system.
- The Family Planning Logistics Management project should be extended for one year (through December 1999) at the current staffing level.

Additional recommendations and details regarding how these lessons learned were developed as a result of this study can be found in this report.

1. Study Objectives

In 1988, the Board of Commissioners for the Commission on Population (POPCOM) designated the Department of Health (DOH) as the lead agency for implementing the Philippine Family Planning Program (PFPP). A subsequent national contraceptive inventory, conducted by the DOH as part of its mandate, revealed a nationwide maldistribution of contraceptives. Contributing in large measure to this situation was the lack of both a rational contraceptive distribution system and a reliable logistics management information system (LMIS).

When the DOH requested assistance, the United States Agency for International Development (USAID) asked the Family Planning Logistics Management (FPLM) project to place a resident advisor at the DOH. It was the start of a long-term project (1991–1998) providing USAID technical and financial assistance for the development of a new contraceptive logistics system. The assistance was provided under the management of the FPLM project based in Arlington, Virginia.

In December 1997, as the project entered its final year of technical assistance in the Philippines, FPLM evaluated the project status and the ability of the new logistics system to provide contraceptives to clients when USAID support ceased.

The study objectives were as follows:

- Document DOH and FPLM efforts in logistics, including strategies, management approaches, and decisions taken during seven years of technical assistance.
- Highlight the lessons learned during the development and implementation of FPLM's technical assistance and logistics interventions that can be used by the DOH and other entities involved in logistics support.
- Develop Composite Indicator scores to determine the logistics situation at midterm, and use these scores to measure progress made over the two years since the baseline scores were completed in December 1995.
- Identify areas to emphasize in 1998, the final year of FPLM involvement, when USAID funding for contraceptive logistics management technical assistance is scheduled to cease.
- Recommend strategies and approaches that the DOH could employ to improve logistics development in the Philippines.

2. The Technical Assistance Strategy

The FPLM project's technical assistance to the Philippines in contraceptive logistics management has evolved over the years as the system has been developed, even as the political situation and infrastructure was changing. Recognition of both the evolution of the project and this changing context is important for understanding and interpreting the results of this program evaluation and the subsequent recommendations.

FPLM II

On arrival at his post in Manila in March 1991 under the FPLM II project, the FPLM advisor conducted a national system assessment and found no rational system in place for ordering, storing, transporting, or managing contraceptives. Exacerbating the situation was the fact that supplies were often allocated equally throughout the provinces without consideration of actual consumption levels. The data that were available were neither disseminated nor used for decision making. Contraceptive needs forecasting was, therefore, based on nonexistent or inaccurate data.

As a result, in some provinces, four to five years' worth of contraceptive commodities expired on the shelves, while other provinces experienced severe understocks and were forced to place frequent emergency orders. Furthermore, stored products spoiled because of poor storage conditions.

At that time, the DOH was delivering contraceptives to its regional health offices (RHO). With few exceptions, local government units (LGU) (i.e., in provinces and cities) had to go to the RHOs to pick up stock. Each district health office (DHO) then picked up supplies at the provincial health office (PHO). Every rural health unit (RHU) and hospital, in turn, collected contraceptives at the DHO.

Deliveries of contraceptives by donor agencies were irregular. In addition, many donors were duplicating the contraceptive methods being delivered by other donors, but health officers could neither control nor organize these allocations, further complicating the ability to plan for adequate stock.

DOH staff themselves were not concerned with logistics issues. The sparse funding for contraceptive distribution at the national level, the scarcity of vehicles at all levels, and the shortage of family planning staff in the RHOs apparently had rendered the logistics issues inconsequential at the central level until FPLM came into the picture.

One of the first activities under FPLM II was the design of a system model to be tested in four regions based on their access, geographic representation (covering each island group), peace and order, and urbanization. The first model tapped into the warehouse and vehicles available in the Region 6 office of POPCOM. Under a memorandum of understanding (MOU) between the DOH and POPCOM, the POPCOM office started delivering contraceptives directly to all service delivery points (SDP) in the region. The DOH's central office, in turn, used USAID funds, originally earmarked for a national contraceptive logistics workshop, to underwrite the associated costs of training, fuel, minor vehicle maintenance, per diems, stationery, and communications.

The second model was conducted in Region 11, with each province and city making quarterly deliveries to their SDPs. FPLM, through USAID, funded the per diems, minor vehicle maintenance, fuel, stationery, and communications.

The third model was tested in the National Capital Region (NCR). Here, the four district offices of the NCR RHO were assigned responsibility for delivering contraceptives to SDPs, and the DOH central office provided financial support for training in the use of system forms.

The fourth model was piloted in selected provinces of Region 4. As in Region 11, the provinces made quarterly deliveries to their SDPs; however, the DOH did not fund delivery costs.

The DOH decided not to test a fifth model, developed by Metro Drug Distribution, a private commercial drug distributor, to distribute contraceptives to all SDPs in a given region. Staff felt that a private distributor would undermine the ability of the LGUs to coordinate their family planning programs.

Data from the contraceptive order forms (COF) were encoded on a simple Lotus spreadsheet developed by FPLM. In all four models tested, contraceptive distribution was relatively smooth. However, because neither the regional DOH nor the POPCOM offices handles data encoding and generation of reports correctly, this job was transferred to the DOH's central office.

In view of the Local Government Code of 1991 (Republic Act No. 7160 passed in late 1991) and the imminent release of implementing guidelines for the Devolution Act by mid-1992, enabling decentralization to take place, the DOH decided that the Region 11 model was the one most applicable to the Philippine situation. They believed it would empower the LGUs to manage their own distribution systems. In the spirit of devolution, the DOH also decided that LGUs should be financially responsible for distribution and that the DOH central office would no longer pay the costs.

The Region 11 model was accepted toward the end of 1992. The implementation strategy had the following features:

- Contraceptives would go directly from Manila to the provinces and cities, instead of the regional warehouses.
- The provinces would deliver contraceptives directly to RHUs, hospitals, and nongovernmental organizations (NGO).
- The provinces and cities would pick up local distribution costs.
- The DOH would give midwives and RHU staff a barangay health station (BHS) worksheet, developed by FPLM with DOH assistance, to help them determine the quantity of contraceptives to be delivered to the BHS.
- Authorized stock levels (ASL) would be based on recent consumption and set at all levels: central, regional, provincial, municipal, and barangay.
- Staff would complete COFs when contraceptives were delivered.
- Data collected on the COFs would go into a national database to provide feedback to local and regional program managers.

FPLM III

Because the DOH budget was inadequate for clearing donated contraceptives through customs and shipping them to the field, USAID asked CARE/Philippines to assist in implementing the Contraceptive Distribution and Logistics Management Information System (CDLMIS). CARE support ran from July 1992 to April 1996, and was conducted in close cooperation with FPLM. One of FPLM's tasks was an

assessment of the logistics training needs of CARE staff. FPLM then designed and implemented an eight-day logistics management training course and an eight-day training-of-trainers course for both CARE family planning program officers (FPPO) and central office staff.

CARE subsequently provided funding for—

- Customs clearance and shipping of contraceptives to the field.
- CDLMIS training (e.g., regional planning workshops, delivery team training, and RHU nurse training).
- Printing of CDLMIS forms.
- One-year grants to 20 LGUs to cover the marginal costs of contraceptive deliveries.
- One FPPO assigned to each of 16 government administrative regions (based in the four CARE area offices) to conduct CDLMIS training and monitoring of implementation in the field.
- Technical assistance to help refine the logistics management information system.

Developing a New LMIS

The steps that went into the development of the CDLMIS are as follows:

- CARE designed a Contraceptive Delivery Order System (CDOS) for tracking shipments to the provinces and cities.
- FPLM contracted with a private firm, AI Innovations, to program the CDOS in Clipper software.
- Under CARE's technical direction, AI Innovations designed and programmed the Contraceptive Commodity Management Information System (CCMIS) for encoding data from COFs and producing summary delivery reports (SDR) for use by the RHOs and LGUs.
- CARE subsequently developed a system in Foxpro software that used CCMIS data to produce management reports (appendix A).

The resulting Contraceptive Delivery Monitoring System (CDMS), using data from the CCMIS, was able to produce a variety of management reports in addition to the summary delivery reports.

The three separate systems (CDOS, CCMIS, and CDMS) were integrated into a single system designed by FPLM—the CDLMIS.

Three data encoders, first hired by CARE and later by FPLM, handled the data encoding until mid-1997, when the DOH's Family Planning Service (FPS) took over this function. However, due to understaffing, FPS required extra help by the end of the year with the transmittal of the SDRs and cover letters to the LGUs and RHOs. FPLM hired temporary data encoders as needed to enable FPS to maintain an updated system.

When PowerBuilder emerged as the new DOH standard software, development of the new LMIS in PowerBuilder was contracted to a private firm, Sybase Philippines.

Selling the New System

Between November 1992 and February 1994, FPLM, CARE, and DOH RHO staff, working in teams, visited provinces and cities to convince local officials—governors and mayors, provincial and city administrators and health officers—of the benefits of the CDLMIS. During each promotional visit, the local chief executive (LCE) of the province received a fact sheet showing the estimated value of the contraceptives the province would receive yearly plus the estimated cost of making quarterly deliveries to the provincial RHUs, hospitals, other government organizations, and NGOs. The fact sheet was designed to convince LCEs to participate in the CDLMIS.

Some LCEs readily signed a memorandum of agreement (MOA) with the DOH that outlined DOH and LGU responsibilities for implementing the CDLMIS (appendix B). Others were reluctant to sign because the issue of family planning had become controversial. A few said they could not sign until their provincial boards had approved and budgeted funds. Of the 110 LCEs in the country, 55 eventually signed the MOAs; those that did not sign the MOA still implemented the program, but could always cease doing so if it became politically expedient. There were no clear differences in implementation between LGUs with signed MOAs and those without them.

Training for Implementation

After the LGUs agreed to participate, their family planning coordinators, provincial health officers, and provincial planning and development officers attended a three-day regional planning workshop. Here, each LGU team laid out a plan for the internal distribution of contraceptives, including where contraceptives would be stored; the delivery routes to be used and the estimated costs involved; and the number of days, teams, and vehicles needed to make a full round of deliveries. The LGUs also identified the delivery team members.

Shortly thereafter, the delivery teams attended a four-day training workshop. It covered the principles of storage and quality assurance, delivery team tasks, and proper record keeping on CDLMIS forms. Trainees also took part in a one-day practicum simulating deliveries to service outlets during which they performed all the tasks except physical delivery of contraceptives.

FPLM and CARE staff also conducted a one-day session devoted to training RHU family planning nurses in the use of the BHS worksheet, contraceptive storage, and quality assurance. A brief practicum prepared them to train the BHS midwives to perform the same tasks. Eventually, approximately 13,000 midwives, 1,800 RHU nurses, 400 delivery team members, and 50 DOH central and regional staff were trained to use the CDLMIS.

The First Rounds

The provincial and city delivery teams started to make deliveries in March 1993. At first, CARE and FPLM staff made regular monitoring and evaluation visits to the LGUs. In November and December of that year, staff from FPLM (including survey experts from the U.S. Centers for Disease Control and Prevention) and CARE conducted a national training impact evaluation. In the process, they visited 151 RHUs, hospitals, and NGOs, and 154 BHSs in 20 provinces and cities in Regions 2, 6, 7, and 11. The regions were selected because they had CARE area offices. The evaluators found no stockouts of Lo-Gentrol at any facility and only two facilities (1 percent) were stocked out of condoms. At the BHSs, 1 percent were stocked out of Lo-Gentrol, and 6 percent were stocked out of condoms.

By early 1994, the entire country had a functioning CDLMIS. Drug availability surveys by the Field Epidemiology Training Program in 1995 and field visits by the USAID-funded Child Survival project team and World Health Organization (WHO) consultants in 1996 all noted the ready availability of contraceptives.

However, the visitors commented on the frequent absence of cotrimoxazole, oral rehydration salts, vitamin A, and two tuberculosis short-course chemotherapy drugs. The DOH requested USAID assistance, through FPLM and CARE, in distributing these drugs, and they were added to Region 6's CDLMIS in July 1995 to see if this change would improve their availability. CDLMIS forms were modified accordingly. Because the DOH wanted closer accountability for the drugs (many were used to treat multiple ailments and had high market values), a dispensed to user record was added to the forms. The BHS worksheet was also modified.

The CDLMIS implementation strategy (i.e., quarterly deliveries backed by USAID financial support for many of the expenses incurred) was essentially repeated in the six provinces and two cities of Region 6. The one-day training for RHU nurses was expanded to two days. All public health physicians from the RHUs, all RHU nurses, and designated family planning nurses attended. The presence of physicians led to greater political support from the RHUs for the new system, and compliance in using the BHS worksheet and storing drugs and contraceptives improved.

After three essential drug deliveries had been made, the DOH's Essential Drugs Distribution (EDD) Steering Committee in charge of the pilot evaluated the results, concluding:

> ... the implementation of the Essential Drug Distribution system in a pilot basis in Region 6 dramatically improved the availability of essential drugs in the RHUs and BHSs of Region 6.
>
> This widespread availability of essential drugs was accomplished without any deterioration in the previous widespread availability of contraceptives in the RHUs and BHSs achieved under the CDLMIS.
>
> The major problem encountered in implementing the EDD system was the late delivery of essential drugs to the LGUs by the DOH.
>
> Based on the results of the EDD pilot implementation in Region 6, the EDD Steering Committee recommended that the EDD system be expanded to two additional regions in CY 1996. This will allow the DOH to gain further experience with the EDD system prior to deciding whether the system could be viable on a national basis.
> (Essential Drugs Distribution Steering Committee meeting notes, mid-1995)

Effect of the LPP Grants on Implementation

As the CDLMIS matured and the full impact of devolution was felt in the field, questions arose as to whether the strong CDLMIS performance, documented in the 1993 joint CARE/FPLM training impact evaluation report, could be maintained. Health workers in the LGUs often complained about the lack of per diems, vehicles, or access to vehicles to deliver supplies. They also said that the CARE grants to select LGUs were too small and too burdensome to administer, and that their one-year duration was too short to encourage the LGUs to implement the CDLMIS successfully.

The decision to have the LGUs absorb the cost of internal contraceptive deliveries was consistent with decentralization but ignored the resource constraints faced by the LGU family planning coordinators trying to implement the CDLMIS. Therefore, cash grants to selected LGUs began in 1995 through the

Local Government Unit Performance-Based Program (LPP). The LGUs used them to buy delivery vehicles, improve storerooms and pay for fuel, vehicle maintenance, and the travel expenses of the delivery team. The environment for implementing the CDLMIS improved dramatically.

An LPP benchmark, which required the provinces and cities to maintain minimum levels of contraceptives in their SDPs or lose their cash grants, motivated the LGUs to implement the CDLMIS as effectively as possible.

Preparing for Institutionalization

Many CDLMIS implementation activities begun by the DOH central and regional offices between 1991 and 1995 were actually completed by FPLM and CARE staff. USAID therefore agreed to support another three-year phase of logistics activities under FPLM III. This phase was to prepare the DOH to assume the operation and funding for all aspects of the system, except the purchase of contraceptives, with minimal deterioration in system performance.

Thus a new Country Strategic and Evaluation Plan (CSEP) was designed by FPLM (as required by the FPLM III contract) with activities focused on—

- Institutionalizing CDLMIS in the DOH.
- Improving stock management at provincial and city levels.
- Adding innovations from the EDD pilot to the CDLMIS.
- Improving the LMIS and converting it to the standard software.

By this time, the DOH was able to fund customs clearing, shipping to provinces and cities, and printing of the CDLMIS forms. The DOH also took a more active role in preparing CPTs for the USAID Mission and calculating quantities to be shipped to the LGUs each quarter. However, delays in contracting procedures, slow payment of forwarders, and substandard performance by contract forwarders dogged the effort, causing frequent delays in shipping.

Until April 1996, CARE had been responsible for shipping contraceptives to LGUs. When the DOH took over this function, it contracted with private carriers who were already supplying the regions with other DOH commodities. The DOH's Family Planning Service (FPS) assumed management of the National Contraceptive Warehouse, located in the POPCOM office compound in Welfareville Compound, Mandaluyong. The drive from the DOH compound should take no more than one hour, but often takes longer because of increasing traffic congestion. The warehouse was not staffed, and FPLM utility workers occasionally assisted FPS staff in organizing and clearing the warehouse.

Assigning counterpart personnel to FPS

The major stakeholders in the CDLMIS are the provinces, cities, and municipalities receiving, distributing, and dispensing the contraceptives to clients. Their roles and responsibilities are described in appendix C.

In June 1993, under FPLM II, the DOH had pledged to provide six new regular positions in FPS to handle family planning logistics. For several reasons, including a moratorium on hiring for new government positions, this pledge went unfulfilled. By late 1995, to develop counterpart personnel who could gradually take over logistics from FPLM's technical assistance group, the DOH assigned four of the current FPS personnel to the logistics section; three more were assigned in June 1997.

Training for institutionalization

At the DOH central and regional office levels, 26 staff members were trained for eight days as CDLMIS trainers in early 1996; 54 participated in the five-day revised CDLMIS and CDLMIS monitoring course. The latter group included Local Government Assistance and Monitoring Service (LGAMS) coordinators in each RHO.

Throughout 1996, a total of 1,137 DOH representatives from local health boards (LHB), LGU family planning coordinators, and delivery team members participated in a three-day training on monitoring the revised CDLMIS at the provincial, municipal, and barangay levels.

Also in 1996, 929 DOH LHB representatives and LGU family planning coordinators attended two-day courses on the revised CDLMIS, as well as RHU staff training. DOH LHB representatives were mandated to use a curriculum provided by the DOH and FPLM for training all RHU staff on the revised CDLMIS. Results were mixed. In a few cases, the training was not conducted at all or, according to DOH representatives, curricula were simply distributed to staff to read. In some cases, where the PHOs felt the training was not satisfactory, retraining was conducted.

In 1997, more staff of DOH central and regional offices were involved with the training—not just from FPS, but also from the Health Manpower Development and Training Service (HMDTS).

The institutionalization-training project exceeded the targeted number of people to be trained, as defined in the 1995 CSEP. The full-time regular DOH personnel assigned to the FPS logistics section increased from four to seven during this period, with an additional two DOH personnel working part-time on the CDLMIS.

Late in 1997, LHB representatives and regional LGAMS coordinators had started to systematically monitor the SDPs, using standardized CDLMIS monitoring instruments.

The DOH also awarded a contract for printing CDLMIS forms to a private contractor, and some forms have been delivered. At the time of the study, the delay in awarding the contract for BHS worksheets, supplies folders, and mailing envelopes might affect the printer's ability to deliver items at the quoted price; the devaluation of the peso had reportedly caused significant increases in the price of paper.

Expanding CDLMIS

In October 1995, the DOH undersecretary for the Office of Public Health Services proposed to the World Bank that the logistics component of their Women's Health and Safe Motherhood (WHSM) project help fund the development and implementation of a successor to the CDLMIS, specifically, the integrated Local Government Essential Drugs Delivery System (LGEDDS).

Project approval was delayed until the DOH satisfied some concerns raised by the World Bank's National Economic and Development Authority. In mid-1997, the DOH invited a number of organizations to submit proposals for providing technical assistance to the LGEDDS project. John Snow, Incorporated, the parent organization of the FPLM project, won the contract, which was signed in January 1998, just about the time the CDLMIS system was in full use. It was expected that the World Bank-funded LGEDDS would be phased-in over the following two years, first implemented in Region 6 and eventually covering nine regions.

3. Study Method

This study was only the second to be undertaken by the FPLM evaluation team and, as such, was less sophisticated than the later studies in the methods and tools used. In addition to reviewing relevant documents (appendix E), the study team undertook the three-part process discussed below.

First, interviews were conducted with key informants representing the relevant stakeholders from government, NGOs, donors, and other private organizations. The interviews were unstructured and free-ranging, with the researchers taking comprehensive notes for later analysis. These key informant interviews occurred before and after the field visits. A list of contact persons appears in appendix D. The stakeholders are listed in appendix C.

The second method of obtaining data entailed field visits to Regions 3 and 6 undertaken by two teams, each made up of logistics advisors from both FPLM/Washington and FPLM/Philippines. These teams used a qualitative questionnaire to obtain overall impressions of the SDPs and the storage facilities. Quantitative data were not collected because such a limited sample would not be representative of the whole country. The regional settings for the field visits are described in the notes for Regions 3 and 6 in appendix F.

Following the key informant interviews, the study team conducted a one-day evaluation of the country's logistics system using the Composite Indicators for Contraceptive Logistics Management. Evaluators were divided into three separate groups (one from FPLM and two from the DOH) for scoring. Their scores were based on their experience with and knowledge of the system, which, in some cases, had been strengthened by the field visits. This process and the tool are described in appendix G.

4. Study Results

Taken together, the 1995 baseline Composite Indicators and the subsequent 1997 midterm Composite Indicators, the key informant interviews, and the evidence from the field trips clearly show measurable progress since the first evaluation in 1995. The logistics system is well established at all levels, compliance is generally good, and users value the system.

Indeed, as table 1 shows, the CDMLIS is well on its way toward achieving sustainability. (A breakdown of scores by group appears in appendix G.) More specifically, program performance is staying on track or improving. The only exception is in organization and staffing, which declined from 12 to 10, primarily because the large staff working with FPLM/Philippines in 1995 had declined in number by 1997. Composite scores in sustainability have doubled and, in some cases, tripled or more.

Multiplying the factors by the constants reveals that, overall, program performance rose slightly from 78.73 to 79.93 percent and that sustainability increased from 24.48 to 70.26 percent (tables G-1 and G-2).

Table 1. Comparison of Composite Indicator Scores, Philippines, 1995 and 1997

Indicator	Potential Score	1995		1997	
		Performance	Sustainability	Performance	Sustainability
LMIS	12	9	1	9	7
Forecasting	8	7	1	7	6
Procurement	8	7	0	8	4
Warehousing and storage	12	8	7	8	9
Distribution	18	14	6	14	12
Organization and staffing	14	12	3	10	10
Policy	4	3	1	3	4
Adaptability	4	3	2	3	3

Note: Numbers are not mathematical averages. They represent the most frequent scores used in the composite of individual group scores displayed in appendix G.

5. General Findings

Overall, the new system was found to be strong, reliable, and understood at all levels visited by the team. Contributing greatly to this success has been the long-term strategy of training staff at all levels, the creation of a logistics section within FPS at the central level, and the presence of a strong, dedicated FPLM staff with low turnover and appropriate population and family planning experience.

However, as the interviews reveal, the new system is still dependent on donors for contraceptive procurement and supply, and the FPS lacks the expertise to utilize the system fully. With uncertainty about what will occur after the coming midyear national elections, the possible reengineering of the DOH, and the effect that the new LGEDDS project will have on the CDLMIS, it is unlikely that full institutionalization will be achieved by the scheduled end of FPLM technical assistance in 1998.

Some constraints encountered during implementation closely parallel the remaining barriers to complete CDLMIS institutionalization. They include ambiguity over the policy-level ownership of the logistics function, insufficient allocation of human resources at the DOH, continuing donor dependence, and problematic transport.

Training

- The massive, nationwide program of face-to-face training undertaken by the project was critical to the success of the CDLMIS. Training began with personnel at the provincial and city levels. The RHU and main health center (MHC) levels then received training and, in turn, trained the midwives at the BHS level. As a result, an army of trained people is in place generating useful, accurate data for managing contraceptive supplies.
- The attempt to have DOH local health board representatives replicate FPLM training on the CDLMIS revisions at their respective RHUs met with mixed results. Training was often not carried out in a timely manner, if at all, and the quality of the training was sometimes questionable.

LMIS

- Most of the staff interviewed are knowledgeable, enthusiastic, committed to the CDLMIS project, and also experienced in the delivery of family planning services.
- All the necessary forms were available at the visited facilities, and doctors, nurses, and midwives at these facilities can complete the forms accurately.
- Record keeping has improved for dispensed-to-user data; BHS worksheets; data for issuance, requisitions, and vouchers; COFs; and other information needed to forecast and order supplies.
- Allocation of supplies, based on real consumption data and routine quarterly deliveries, is leading to less product wastage.
- Procedures for transferring overstocks to understocked areas have been established, with decisions on transfers made by provincial and city delivery teams.
- Clear authorized stock levels have been established throughout the system.

- Monitoring and evaluation procedures are in place, and DOH LHB representatives and other DOH staff have noted compliance with these procedures on the standard forms developed by the project.
- The FPLM resident advisor and his team have been ensuring the progress of the CDLMIS at the central level, which lacks sufficient CDLMIS support staff.
- Support from the one-year, USAID-funded LPP grants was essential to successful functioning of the CDLMIS at the LGU level.

Institutionalization

- FPS does not have enough counterpart staff to assume all logistics responsibilities once USAID support is withdrawn. This situation is compounded by the threat of disruptions resulting from a change in government and the probability that some personnel currently in logistics may be transferred back to their original civil service jobs.
- The DOH is on schedule in funding the activities listed in the Institutionalization Plan (appendix H).

Storage

- Good storage procedures (e.g., first-to-expire, first-out) are in place at all SDPs.
- Storage facilities at the provincial and city levels need further improvement.
- The lack of staffing at the general warehouse requires FPS staff to spend valuable time clearing inward shipments to the warehouse and supervising offtakes of stock every quarter.

Transport

- LGUs not receiving LPP grants do not always have access to vehicles, which LGU staff use or commandeer for other duties or, sometimes, for private use.
- Recurrent costs for maintenance and fuel are emerging as important concerns with the pending withdrawal of USAID financial aid.
- Per diems do not cover overnight stays. The teams often have to return to base and then make the long journey back to the LGU the following day, wasting fuel and time.

LGEDDS

- Even under a best-case scenario, several months of project implementation time will be lost when the FPLM resident advisor and three logistics advisors move to the LGEDDS project.
- Because the LGEDDS delivery system will be fully integrated, contraceptives will command the same treatment as essential drugs. However, the pipeline might be shortened because of the shorter life of drugs or the inability of the government to buy drugs in large quantities as they do contraceptives.

- A number of benefits from LGEDDS may accrue to the CDLMIS, as follows:

  - Access to resources, especially transport, will increase as more personnel become involved in supplying essential commodities to health facilities.
  - Training at the grassroots level is now two to three years old. LGEDDS can incorporate the major CDLMIS retraining that should take place soon
  - If the family planning coordinator at the regional, provincial, or city level proves to be less capable than desired, one or more of the other technical coordinators can lead logistics training, distribution, and monitoring.
  - Improved delivery of essential drugs is more attractive to many public officials and public health officers than the delivery of contraceptives. LGEDDS should, therefore, result in more support for the entire logistics program.
  - The expanded package of essential drugs will facilitate the DOH's plan to involve the Department of Interior and Local Government in securing LGU compliance with logistics management requirements.
  - USAID's investment in CDLMIS and EDD has moved the DOH into a more efficient, integrated essential drugs distribution system. LGEDDS has the potential to serve as a base for moving toward a total reproductive health and maternal and child health package in line with current USAID policy on reduction in the population growth rate and improvement in maternal and child health.

6. Lessons Learned

The rich development and implementation experiences with the CDLMIS suggest several lessons to be considered for the remaining life of this project and for implementing similar projects, specifically the LGEDDS project to develop the successor to the CDLMIS.

1. **Running a system as a distinct project with full external funding, a long-term resident advisor, and dedicated local staff is less complicated than institutionalizing it into a government agency.** In the Philippines, institutionalizing the system at the central government level has proven problematic and is taking longer than expected. The FPLM project has a limited bureaucracy and can act faster and with more flexibility than a government department in such matters as establishing compensation levels, using personnel, and procuring and paying for goods and services. The presence of an in-country FPLM office was instrumental to the success of the CDLMIS in the Philippines.

2. **Spreading responsibility for the same function across two or more government offices causes confusion in the field and makes the work of the technical assistance team more difficult.** Coordinating meetings with staff from multiple divisions, facilitating communication among them, and securing authorization signatures from multiple division leaders can drastically delay activities and stall progress toward program goals. This lesson should be especially taken into account in the Philippines when the LGEDDS project is implemented because some of its major stakeholders are situated in three different DOH offices: the Office for Public Health, the Office for Special Concerns, and the Office for Management Services.

3. **A logistics section with dedicated full-time staff within the health ministry must take charge of the logistics system if sustainability is to be achieved.** The Philippines experience suggests that sustainability could have been achieved sooner if staffing issues had been resolved at the start of the project and designated positions had been filled. Current improvements are addressing senior accountability and presence, but more time would have been available to achieve sustainability if such problems had been resolved much earlier.

4. **Cumbersome, bureaucratic procedures in bidding and awarding shipping contracts and paying for freight-forwarding services can make it difficult to ensure timely delivery of contraceptives to facilities at the lower levels.** Outsourcing contraceptive distribution to the regional capitals in the Philippines to a private freight-forwarding company should have improved efficiency and ensured timely deliveries. However, a series of one-year contracts that could take months to be approved and the delays in paying invoices—both due to complicated bureaucratic procedures—actually resulted in major delays and threatened to produce stockouts of contraceptives throughout the country.

5. **Outsourcing particular, clearly identified, parts of the system can be an efficient use of resources.** The use of the expertise of a local firm, Sybase Philippines, to develop the LMIS software contributed to the success of the system and has enabled ongoing technical support. The existence of this local resource for designing and providing technical support for the LMIS software will also reinforce the sustainability of that critical element of the logistics system.

6. **Utilizing other services within the health ministry to support the logistics system can maximize sustainability.** The involvement of HDMTS and LGAMS in CDMLIS training in the Philippines helped increase sustainability by integrating these services into the overall monitoring and implementation of the CDLMIS.

7. **Health workers at the regional level must receive high quality, face-to-face training to motivate and equip them with the skills they need to perform their roles in the system and ensure sustainability of the contraceptive logistics program.** Stakeholders in the Philippines regard intensive CDLMIS training for all DOH and LGU staff who provide family planning services as a fundamental activity for sustainability. The FPLM team found that face-to-face training resulted in stronger ownership and a greater investment in CDLMIS by health workers. However, the attempt to have DOH LHB representatives replicate the FPLM training on the CDLMIS revisions with their respective RHUs met with mixed results, as training was not always completed in a timely manner and quality control was difficult.

8. **Using clear, simple, standardized LMIS forms throughout the country makes the forms more user-friendly to staff providing family planning services.** In the Philippines, staff at all levels easily understood the uniform CDLMIS forms, which means they are more likely to complete the forms accurately and update them with some regularity.

9. **Outside support grants can help ensure a successful LMIS at the lower levels.** In the Philippines, LPP grants went to buy delivery vehicles, improve storerooms, and pay for fuel, vehicle maintenance, and the travel expenses of the delivery team. This funding helped the LGUs implement the CDLMIS in a shorter time period and to ensure that the products would reach clients in good condition.

10. **Constant monitoring of the system maintains an efficient and strong LMIS.** Regular monitoring of stock on hand (SOH), authorized stock levels, consumption levels, and emergency orders by the delivery teams and the DOH representatives in the Philippines has strengthened the CDLMIS and its ability to provide critical information for decision making.

11. **An efficient LMIS can encourage the integration of drug supplies.** The experience in the Philippines shows that a well-established system for distributing and monitoring contraceptives can serve as a basis for its expansion to include other drug commodities. The willingness of the Philippine Government to invest in LGEDDS based on the CDLMIS by using hard loan money from the World Bank is a tribute to the success of CDLMIS.

7. Recommendations

The CDLMIS is now a fundamental element of the Philippine public health system. As a direct result, a similar system for combining essential drug and contraceptive deliveries—LGEDDS—will soon be underway. The major remaining task now is to capitalize on the CDLMIS progress made at lower levels by strengthening the system at the central level.

1. *Discussion*: To continue the process of full institutionalization of CDLMIS, some staff within the management information system (MIS) and logistics sections need further training. It would, therefore, be appropriate for the present FPS logistics chief, the MIS section head, the chief of the Monitoring and Evaluation Division, and the FPS director (under whom the logistics function falls) to attend FPLM's biannual training in logistics management during 1998. This course is designed for both staff who operate a family planning logistics system directly and staff who manage this function. Individuals in these four positions do not yet have a full appreciation of the logistics system procedures, mechanism, and, above all, of the complexity of its intrinsic functioning. Without adequate training, there is a risk that they will underestimate this activity and not provide adequate resources and levels of accountability. In addition, the FPS director would be in a better position to champion the need for a strong, well-supported family planning logistics function within the DOH if he is formally trained in logistics management. The course announcement appears in appendix I.

   Recommendation: Central-level staff should be formally trained in logistics management during 1998 through FPLM's international training in Arlington, Virginia.

2. *Discussion*: Good communication channels and efficient data collection systems are vital to understanding and acting on logistics challenges. It therefore makes good sense to house the logistics section and the MIS section together.

   Recommendation: The DOH should house all logistics and MIS staff in the same building at the DOH compound.

3. *Discussion*: The CDLMIS works efficiently only when data are current. However, because of the change in data encoders and the volume of work, there is a data entry backlog. This backlog needs to be cleared quickly to allow DOH staff to concentrate on entering and analyzing current data so that they can advise on interventions. Clearing this backlog will also enable calculation of the benchmark data for 1997, which is behind schedule.

   Recommendation: FPLM/Philippines should hire two temporary data encoders for one to two months to help clear the data entry backlogs.

4. *Discussion*: To generate enthusiasm among DOH data encoders and statisticians for the relatively new work procedures, these personnel need some field orientation on the origins of the data they are entering. In this way, they can gain further ownership of the process, thereby quickening the pace of institutionalization.

   Recommendation: Data entry staff should take short field visits to help them better understand the source of the data they manage as well as the constraints encountered by the field staff who collect the data.

5. *Discussion*: As part of the continuing institutionalization process mandated by FPLM III, the Management Advisory Service (MAS) and CDLMIS staff should identify one or two people in the

DOH logistics section who can act as troubleshooters for the computerized LMIS as soon as the technical and operational manuals are produced.

Recommendation: The MAS should assign a technical backstopper to the LMIS.

6. *Discussion:* Close coordination of activities and cooperation between the designers and the managers of the CDLMIS and the new LGEDDS can help safeguard the family planning component of LGEDDS.

   Recommendation: Establish the maximum possible communication and collaboration between CDLMIS and LGEDDS.

7. *Discussion*: Despite all the training and the clear support for CDLMIS from top DOH management, some field-level staff still seem uncertain as to whether they should undertake CDLMIS-related activities.

   Recommendation: The DOH should issue a department order clearly defining the role of LGAMS and the DOH LHB representatives, HMDTS and regional field office trainers, and MAS and Procurement and Logistics Service (PLS) in the institutionalization of CDLMIS. The chief of the FPS logistics section should draft this order for review and comment by the services involved and forward it the final version to the Office of the Secretary for signature.

8. *Discussion*: Although the DOH personnel attached to the contraceptive logistics function could assume some of the roles now filled by donor-funded technical assistance groups, there are not enough counterpart staff to assume all the roles. In addition, it is possible that some personnel currently in logistics functions may be transferred back to their original civil service jobs. These issues, among others, have stalled the institutionalization of logistics functions at the central level. Assuming that the USAID Mission grants the FPLM request for the U.S.$1.3 million in field support funds in FY 1998, no additional funds will be required for FPLM's proposed one-year extension. This situation has been made possible because of tight financial management of the project by FPLM, including the use of local technical assistance rather than international technical assistance, and the continuing devaluation of the peso. A one-year extension at full staff levels would provide the extra time needed to accomplish the following:

   - Include all 110 LGUs (not only those who receive LPP grants) in the Warehouse Management Improvement Program for 1998.
   - Evaluate the training on the revised CDLMIS that DOH LHB representatives are giving RHU staff. Retraining should be considered in those areas where training was not performed to a high standard. This effort would be concentrated in the LGUs in those four regions where training at this level will not be undertaken by LGEDDS project staff.
   - Follow up on DOH LHB representatives and other DOH staff who received training in CDLMIS monitoring to ensure they are monitoring field implementation regularly.
   - Train additional FPS staff to prepare CPTs, allocate contraceptives to LGUs, and review SDR printouts and cover letters prior to sending them to the LGUs and RHOs.
   - Train new FPS staff in CDLMIS if any key personnel are transferred out of FPS or the logistics section after the elections when the new administration begins operations.
   - Advocate for CDLMIS, and orient the new Secretary of Health and his or her key staff once the new administration takes office.

- Recruit a new expatriate resident advisor when the current advisor moves to the LGEDDS project and recruit and train new local-hire logistics officers to continue FPLM's efforts in institutionalizing CDLMIS.
- Determine whether the DOH data encoders can complete the required workload. If the project was too optimistic in releasing all three of its data encoders at the same time, the DOH should use one or two FPLM-hired data encoders.
- Assist FPS as it attempts to resolve problems with the timely shipping of contraceptives to the LGUs.
- Continue close coordination with LGEDDS project operations to ensure that availability of contraceptives at the service outlets is not reduced as a result of CDLMIS absorption into LGEDDS.

Recommendation: The FPLM project should be extended for one year (through December 1999) at the current staffing level.

These recommendations, if implemented, will improve the chances of full institutionalization of the CDLMIS by the end of 1999.

Appendix A.
CDLMIS Reports

APPENDIX A Reports Produced by the CDLMIS

DESCRIPTION:

SDR Cover Letter

The SDR Cover Letter to the PHO/CHO is a detailed report of the findings and recommendations of the analysis of the recently concluded Delivery Run of the Province/City. The letter identifies any problems in the field which need follow-up or intervention by the Province/City and the monitoring team from the Regional Office.

This letter and the SDR printout provide a bird's eye view of the actual supply status of the facilities being reported and the overall functioning of CDLMIS of the Province/City from the facility level up to the provincial warehouse level.

ITEM DESCRIPTION:

❶ *SDR Cover Letter Address* - contains the name, consignee code, and address of the consignee of the Province/City.

❷ *PART I SDR Analysis* - This part of the letter lists all the findings and recommendations from the processed Summary Delivery Report of the Province/City. The following are the possible findings and recommendation that CDLMIS will generate for the Province/City:

- *Compliance Status (Part I no. 1)* - this part of the memo reports any discrepancies together with the list of facility names. The following is the information being reported by this part of the letter:
  - *Number of Received COFs* - the number of COFs received out of the Expected Total Number of COFs to be reported for the Delivery Quarter. This includes the EXCLUDED facilities with COF. They are considered reported although not completely processed in the Summary Delivery Report.
  - *Facilities Not Reported for the Delivery Quarter* - facilities on this list are those expected to have deliveries for the Delivery Quarter but for which no COFs were received.
  - *Recently EXCLUDED COFs* - these are COFs which have been EXCLUDED for this reported Delivery Quarter. These facilities are counted as reported but the COFs are not completely processed in the Summary Delivery Report. These COFs need to be corrected by the Delivery Team so that they can be completely processed and included in the SDR.
  - *Previously EXCLUDED COFs* - these are the facilities whose COFs were previously EXCLUDED. The Delivery Team has to correct these COFs or the data for these facilities will not be completely processed in the SDR.

- *Stocked Out Facilities (Part I no. 2)* - this part of the letter lists the names of facilities with NO STOCK ON HAND OF A PARTICULAR CONTRACEPTIVE at the time the Delivery Team arrived at the facility.
- *Balance End of Last Delivery Discrepancy (Part I no. 3*)- this part of the memo lists the name of facilities whose Balance End of Last Delivery does not match with the computer Ending Balance from the previous delivery. These facilities are not EXCLUDED from the SDR because the discrepancy is not so severe as to give a negative value. The discrepancies in the ending balance of these facilities can be corrected by the computer during data processing. Those facilities which cannot be corrected by the computer and with irreconcilable errors are reported as EXCLUDED Facilities.
- *Facilities with Mathematical Errors (Part I no. 4)* - this is the listing of facilities with mathematical errors in the computation of the COFs. The mathematical errors being reported at this part of the memo are the main mathematical errors only, so if the errors are due to a 'Domino Effect' only the main mathematical error will be reported by the system. Mathematical errors in the AMU computation will be filtered by the system to distinguish real rounding off errors.
- *Discrepancies in the quantity of the Stock Delivered/Removed between the COF and RIV (Part I no. 5)* - this is the listing of facilities with discrepancies in stock removed/stock delivered of the COF as against the RIV being issued.

3. *PART II Inventory Report Analysis* - starting from this paragraph all the findings from the processed CDLMIS Inventory Report of the Province/City are stated.

4. *Missing CDLMIS Inventory Remark* - if this statement is printed in Part II of the Cover Letter it means that the CDLMIS Inventory Report of the Province/City was not included with the CDLMIS forms sent to DOH Central Office by the Consignee.

5. *Discrepancies and Mathematical Errors* - this part of the analysis flags down the discrepancies and errors arising from mathematical or processing errors in filling up the CDLMIS Inventory Report. The following are the possible discrepancies and errors that would likely be picked-up during processing of the encoded inventory report:
   - *Discrepancies in the BEG. BALANCE OF INVENTORY (Section A)*- this discrepancy occurs when the reported Beginning Balance of the Inventory Report does not tally with the previous Computer Recorded Balance. Having this discrepancy affects the whole computation of the Inventory Report for the said contraceptive. Succeeding computations of the Inventory Report are already considered mathematical errors.
   - *Discrepancies in the Excess Stock Removed (Section B3)* - this discrepancy occurs when the reported Excess Stock Removed in the Inventory Report does not tally with the Summary Delivery Report Total Excess Stock

Removed.

- *Discrepancies in the Emergency Order Given (Section C1)* - this discrepancy occurs when the reported Emergency Order Given in the Inventory Report does not tally with the SDR Total Emergency Order Issued from the Delivery Quarter being reported.
- *Discrepancies in the Stock Delivered to the Facilities (Section C3)* - this discrepancy occurs when the reported Stock Delivered to the Facilities in the Inventory Report does not tally with the SDR Total Stock Delivered from the Delivery Quarter being reported.
- *TOTAL ADDITION ERROR (Section B)* - errors in the addition of the Total Adjustments in Section B of the Inventory Report.
- *TOTAL DEDUCTION ERROR (Section C)* - errors in the addition of the Total Adjustments in Section C of the Inventory Report.
- *SOH PER STOCK CARD ERROR (Section D)* - errors in the computation of the Stock on Hand per Stock Card of the warehouse (i.e. [Section A + Section B - Section C]).

- *Special Notes from Central Office* - This section states certain reminders, remarks, and recommendation from DOH Central Office to the Province/City on the following items:
  - *LPP Benchmark Rating* - the LPP Benchmark rating of the Province/city for the delivery run.
  - *Arrival of the Delivery Data* - states when the CDLMIS forms from the Province/City were received by DOH Central Office. The number of days stated pertain to the number of days after the last day of Delivery. Allowable grace period is 14 days, more than 14 days is considered late by the system.
  - *Date of Expected Start of Next Delivery Run* - is the date computed by the system when the next delivery run of the Province/City should start, based on their submitted COFs.
  - *Other Reminders from DOH Central Office* - other reminders or notices that the DOH Central Office would like to give the Delivery Team, Consignee, or Province/City.

7 September 1995

❶

EFREN SORIANO, M.D.
PROVINCIAL HEALTH OFFICER
PROVINCIAL HEALTH OFFICE
MORONG, RIZAL

04-09-01-000-000-28

Attention: CDLMIS Delivery Team

Dear Dr. Soriano:

Enclosed please find the CDLMIS Summary Delivery Report and the CDLMIS Inventory Report printout for RIZAL for the 1995 3RD QUARTER round of contraceptive deliveries.

Thank you for the prompt submission of the forms which made the timely production of the Summary Delivery Report possible.

❷

PART I SDR Analysis --- In analyzing the Summary Delivery Report, we noted that:

1. We received 71 COFs and RIVs out of 74 facilities expected to receive contraceptive deliveries.

   We did not receive any Contraceptive Order Forms (COFs) and RIVs from the following facilities, and therefore assumed that no delivery was made to these facilties:

   Facility
   NEW ERA
   LAKEVIEW
   GEN. TRIAS MCH

   Please send the COFs and RIVs if deliveries were made to these facilities.

   The COFs from the following Facilities were TEMPORARILY EXCLUDED from the Summary Delivery Report becouse of the following reasons:

Facility	Remarks
PILILLA MC	Ending Balance Discrepancies (w/ negative values)
CENTURY TEXTILE MFG.	SOH greater than Total Available

   We would also like to followup the COFs from facilities which were temporarily excluded from the previous SDR which are marked as 'PRV. EXCLUDED COF, NEEDS F-UP' on the Summary Delivery Report for this quarter:

   Facility
   BULUSAN RHU
   SILANGAN RHU

   Could you please send the corrected COFs and/or RIVs of the current EXCLUDED facilities and the PRV. EXCLUDED facilities so that we could make the necessary revision on your next Summary Delivery Report.

2. The following facilities had STOCKOUTS at the time the Delivery Team arrived:

Facility	Stock Description
SAN MATEO RHU III	CONDOM
TAYTAY RHU II	CONDOM
RODRIGUEZ RHU I	DMPA

3. The following Facilities' BALANCE END OF LAST DELIVERY, column A on the COFs did not tally with the ENDING BALANCE on the SDR of the last delivery. The Facilities' BALANCE END OF LAST DELIVERY have been corrected by the computer. Please take note of the new ENDING BALANCE on the Summary Delivery Report for this Quarter as this is the correct balance to be used for the next Delivery Run of the following Facilities:

Facility	Stock Description
JALA-JALA RHU	LO-GENTROL
CAINTA RHU I	CONDOM
FILSHUTTERS	CONDOM
BINANGONAN RHU II	DMPA
SAN MATEO RHU I	IUD

4. Mathematical errors in the calculation on the COFs for the following facilities were discovered:

Facility	Stock Description	Mathematical Error
TANZA RHU	LO-GENTROL	AMU Error
G & B EXPORT	CONDOM	Total Available Error

May we suggest that you review your COFs for these facilities for any inadvertent error that may have been made.

5. There were differences in the quantity delivered/removed between the COF and the RIV in the following Facilities:

Facility	Stock	COF	RIV
MAGSAYSAY RHU	CONDOM	120	220
TANZA RHU	LOGENTROL	253	293

❸

PART II. --- In analyzing the CDLMIS Inventory Report for 953RDQTR, we noted that:

❹

NO CDLMIS INVENTORY REPORT WAS RECEIVED WITH THE DELIVERY DATA SUBMITTED TO CENTRAL OFFICE. Please send us the copy of the CDLMIS Inventory Report as soon as possible so we can complete the calculation on how much contraceptives to send to your province.

There were discrepancies and errors between the following Balances reported in the CDLMIS Inventory Report as against the computer-calculated balances.

	Stock Description	ACTUAL	CORRECTED	DIFFERENCE
Beginning SOH Actual Count of the Last Reported Delivery Quarter	LO-GENTROL	95,400	102,000	6,600
Excess Stock Removed	LO-GENTROL	125	90	-35
	CONDOM	223	180	-43
Emegency Order Given	CONDOM	200	220	20
Stock Delivered to Facilities	LO-GENTROL	41,800	40,900	-900
	DMPA	6,394	7,109	715
TOTAL ADDITIONS	LO-GENTROL	7,100	7,000	-100
TOTAL DEDUCTIONS	DMPA	3,622	3,522	-100
SOH PER RECORD	CONDOM	52,600	55,600	3,000

May we suggest that you review the SDR and the CDLMIS Inventory Report that you have submitted to us in order to identify the causes of discrepancies.

Finally, may we note that:

- For the LPP Benchmark 93.1% of your facilities have at least one month supply of Lo-Gentrol and Condom for this quarter's delivery run. If you maintain or even improve this performance through the next national benchmark assessment, you will be able to pass the LPP Logistics benchmark.
- The CDLMIS forms were received by the Central Office 37 days after the last day of Delivery. 'CDLMIS forms received by Central Office more than 15 days after the last day of Delivery, cause delays in shipment of commodities to your provincial warehouse and processing of the SDR.
- The next Delivery Run in your Province is expected to start on November 21, 1995 as computed by the system.

Thank you and best regards.

Very truly yours,

JOVENCIA B. DUMINDIN-QUINTONG, M.D., M.P.H.
Director III

cc: Dr. Ethelyn P. Nieto
Regional Health Director
QMGH Compound, Project IV
Quezon City

Appendix B.
Memorandum of Agreement

Republic of the Philippines
Department of Health 20
OFFICE FOR SPECIAL CONCERNS
FAMILY PLANNING SERVICE
Manila

May 6, 1994

Dr. Ricardo Trinidad
Regional Health Director
Regional Field Office No. III
San Fernando, Pampanga

Attention: Dr. Edna Abcede
FP Coordinator

Dear Dr. Trinidad:

Attached for your file and reference are the three (3) copies of the signed Memorandum of Agreement (MOA) between the Department of Health and Zambales, Tarlac and Olongapo City and Angeles City on the new Contraceptive Distribution and Logistics Management Information System (CDLMIS).

Kindly furnish one (1) copy of the signed MOA to the Office of the Governors of Zambales and Tarlac and Office of the Mayors of Olongapo City and Angeles City.

Thank you for your continued support to the Philippine Family Planning Program.

Very truly yours,

Carmencita Reodica

CARMENCITA N. REODICA, M.D., M.P.H., CESO II
Assistant Secretary for Special Concerns

cc: CARE Central Office
CARE North Area Office

"Family Planning Saves Lives"

EVELYN V. PAR
Provincial Population
Officer IV
Province of Zambales

MEMORANDUM OF AGREEMENT

KNOWN ALL MEN BY THESE PRESENTS:

That this MEMORANDUM OF AGREEMENT entered into by and between:

HON. AMOR D. DELOSO
Provincial Governor
Province of Zambales

The DEPARTMENT OF HEALTH through the DOH-Regional Field Office No.III, located at San Fernando, Pampanga, represented herein by Dr. Ricardo Trinidad, Regional Director, pursuant to Department Order No. 104-A series of 1993 dated March 29, 1993, and hereinafter referred to as the FIRST PARTY.

-and-

The LOCAL GOVERNMENT OF THE PROVINCE OF ZAMBALES, with principal address at the Provincial Capitol, Zambales represented herein by the HON. AMOR D. DELOSO, in his capacity as the Provincial Governor, and hereinafter referred to as the SECOND PARTY,

WITNESSETH:

1. That the contracting parties bound by common good and public interest agree that there is need for an effective contraceptive distribution and logistics management information system to be installed in the Province of Zambales to ensure an accurate forecast, allocation, and timely distribution of commodities/logistics for the successful implementation of the Philippine Family Planning Program (PFPP);

2. That such a system can best be achieved in the said province/city by the utilization of the combined resources of the two parties;

RICARDO TRINIDAD, M.D.
Regional Health Director
Regional Field Office No. III
San Fernando, Pampanga
Department of Health

3. That the Contraceptive Distribution and Logistics Management Information System (CDLMIS) to be jointly implemented by the parties has the following distinguishing characteristics:

   a) Direct shipment or delivery of contraceptives from Manila to the province/city;

   b) Direct quarterly delivery by the Province/City concerned to all rural health units (RHUs), hospitals, Non-Government Organization (NGO) clinics, and other Government Organization (GO) clinics;

   c) Setting of authorized stock levels (ASL) for every service outlet, based on actual recent past consumption;

   d) Completion of an order form at the time of delivery which is entered into a computer at DOH - Central Office immediately after delivery forming the basis for a contraceptive commodity management information system;

EVELYN V. [illegible]
Provincial Population Officer IV
Province of Zambales

HON. AMOR D. DELOSO
Provincial Governor
Province of Zambales

e) Conducting a training for delivery team members in CDLMIS and a training for the RHU nurses on use of the Barangay Health Station (BHS) Contraceptive Order Worksheet;

f) Maximum use of Barangay based volunteer workers to resupply clients who received their initial supply from a Local Government Unit (LGU), DOH, NGO or other GO Clinic;

g) Shouldering of internal distribution costs by the SECOND PARTY.

4. That the project document entitled "Contraceptive Distribution & Logistics Management Information System" (CDLMIS) for the SECOND PARTY, which document is hereto attached as Annex A, is hereby made an integral part of this Agreement;

NOW, THEREFORE, for and in consideration of the aforesaid premises, the parties further agree to assume the following functions and responsibilities:

1. The FIRST PARTY in its role as the lead Agency in coordination and implementation of the PFPP shall:

1.1 Provide a continued supply of the right amount of contraceptives;

1.2 Ship these contraceptives directly to the SECOND PARTY (under the CARE, Philippines assisted project);

1.3 Provide the necessary guidelines and standards to the SECOND PARTY in the establishment and operationalization of the CDLMIS;

1.4 Propose thru the DOH representative, pursuant to the pertinent provisions of the Local Government Code of 1991 (RA 7160), budgetary allocations to the Sanggunian concerned, for the operation and maintenance of the SECOND PARTY's delivery team/s in its internal contraceptive distribution as well as to others concerned relative to CDLMIS;

1.5 Provide (under the project of CARE, Philippines) the necessary technical assistance and other institutional support to the SECOND PARTY for the smooth implementation of the following activities, to wit:

a) Regional Planning Workshop
b) RHU Nurses Training on BHS Worksheets
c) Training of Delivery Team members
d) Mid-Year Assessment/Year-end Assessments
e) CDLMIS reports and forms

RICARDO TRINIDAD, M.D.
Regional Health Director
Regional Field Office No. III
San Fernando, Pampanga
Department of Health

EVELYN V. [illegible]
Provincial Population
Officer IV
Province of Zambales

HON. AMOR D. DELOSO
Provincial Governor
Province of Zambales

1.6 Provide the necessary travelling and meal allowance of its regional family planning (FP) coordinator in monitoring the CDLMIS;

1.7 Monitor the project's implementation with the assistance of the CARE Regional Family Planning Project Officers (FPPOs) and the Regional Field Office Family Planning Coordinator;

1.8 Analyze and validate the quarterly delivery report and other field data/forms;

1.9 Provide the SECOND PARTY with computer print-out and other feedback concerning the CDLMIS implementation;

1.10 Provide office space for the regional FP project officer of CARE, Philippines in the DOH-Regional Field Office concerned for an effective collaboration;

1.11 Take such other actions in consultation with the SECOND PARTY as are necessary for the smooth implementation of the project;

2. The SECOND PARTY shall:

2.1 Designate the office(s) responsible for implementing and managing the CDLMIS in the Province/City concerned;

2.2 Install and operationalize the Contraceptive Distribution and Logistics Management Information System (CDLMIS) according to approved DOH guidelines and standards;

RICARDO TRINIDAD, M.D.
Regional Health Director
Regional Field Office No. III
San Fernando, Pampanga
Department of Health

2.3 Issue memoranda, office orders or circulars enjoining all participating agencies to adhere to the requirements of the CDLMIS;

2.4 Ensure the proper and efficient functioning of its Local Health Board as an advisory committee for the Sanggunian concerned on health matters such as but not limited to, the necessity for, and application of, local appropriation for public health purposes consistent with the technical and administrative standards of the Department of Health;

2.5 Ensure the attendance of all concerned/involved LGU personnel to the training activities;

EVELYN V. KHO
Provincial Population Officer IV
Province of Zambales

HON. AMOR D. DELOSO
Provincial Governor
Province of Zambales

2.6 Organize Provincial/City delivery team(s) to distribute the contraceptive requirements of all the service outlets above the BHS level on a quarterly basis;

2.6.1 Provide the vehicles, drivers, and technical staff needed by the said Delivery Teams;

2.6.2 Provide such necessary operating expenses allowed under standing accounting and auditing rules and regulations as may be needed by the said delivery teams in the quarterly distribution run;

2.6.3 Submit to the FIRST PARTY and the CARE Regional FPPOs the required forms within five (5) working days after having completed each quarterly distribution run. This should be sent thru the fastest means right after the delivery runs.

2.7 Designate the responsible local government office and/or official who shall be accountable for the consignment of contraceptives received from the FIRST PARTY;

2.8 Maintain an appropriate storage area for FP Contraceptives.

It is hereby stipulated that this Agreement shall be valid and in force for a term of (3) years commencing on the date of signing of this Agreement by the parties.

RICARDO TRINIDAD, M.D.
Regional Health Director
Regional Field Office No. III
San Fernando, Pampanga
Department of Health

IN WITNESS HEREOF, the parties have hereunto affixed their signatures as follows:

(Place)	(Place)
(Date)	(Date)
DEPARTMENT OF HEALTH Thru the DOH-Regional Field Office No. III (FIRST PARTY)	PROVINCIAL GOVERNMENT OF ZAMBALES (SECOND PARTY)
BY:	BY:
RICARDO J. TRINIDAD, M.D. Regional Health Director Regional Field Office No. III DEPARTMENT OF HEALTH	HON. AMOR D. DELOSO Provincial Governor Province of Zambales

Conforme:

JUAN M. FLAVIER, M.D., M.P.H.
Secretary of Health
Department of Health

SIGNED IN THE PRESENCE OF:

EVELYN V. [illegible]
Provincial Population Officer IV

ACKNOWLEDGMENT

Republic of the Philippines)
Province of _____) s.s.
Municipality of _____

Before me, this 26 APR 1994 day of _____, 19__ in the municipality of _____, Province of _____, Philippines, personally, appeared _____, with Community Tax Certificate No._____, issued at _____ and _____, with Certificate No. _____, issued at _____, known to me to be the same person who executed the foregoing instrument, and they acknowledged to me that the same is their free act and deed.

This instrument, consisting of _____ pages, including the page on which this acknowledgement is written, has been signed on each and every page thereof by the parties and their witnesses, and sealed with my notarial seal.

IN WITNESS WHEREOF, I have hereunto set my hand, the day, year and the place above written.

CARLOS S. GALICIA
NOTARY PUBLIC
Until December 31, 1994
PTR NO. 152137
ISSUED ON 1-18-94

Page No. 14;
Book No. 37;
Series of 1994.

EVELYN V. MAR
Provincial Population
Officer IV
Province of Zambales

ANNEX A

Contraceptive Distribution and Logistics Management Information System (CDLMIS) for the Province of Zambales

HON. AMOR D. DEUÑOSO
Provincial Governor
Zambales

The Province of Zambales will field delivery teams which will make quarterly deliveries of contraceptives to approximately 24 facilities (17 RHUs, 1 NGOs, 6 Hospitals).

The team will consist of Ms. Benita Dalan, FP Coordinator, Ms. Francisca Abad, PPO III, Ms. Hilarion Verzosa, Jr., Supply Officer, Mr. Romeo Elamparo, PPW II (alternate), and a Driver. The team will deliver to 24 facilities in Subic to Sta Cruz using Toyota Hi-Lux 4x4 (PHDP vehicle) as its main vehicle. The team will spend approximately 6 working days per quarter in delivering contraceptives.

The delivery runs by the team for the first year are scheduled for January, April, July and October 1994.

The estimated budget to be borne by the Province of Zambales for the four delivery runs in 1994 is as follows:

1.	Per diems	P15,000.00
2.	Other transportation cost	0.00
3.	Fuel & Vehicle Maintenance	45,000.00
4.	Communications	500.00
	TOTAL	P60,510.00

Contraceptives sent to the Province of Zambales by the Department of Health Central Office will be consigned to

DR. ARCELIE DE GUIA-LLAMADO, M.P.H.
Provincial Health Officer II
Provincial Health Office
Iba, Zambales

RICARDO TRINIDAD, M.D.
Regional Health Director
DOH-Regional Field Office No. III
San Fernando, Pampanga

The contraceptive supplies of the Province of Zambales will be stored at the Provincial Health Office-Storeroom, Zambales.

Appendix C.

CDLMIS Stakeholder Roles and Responsibilities

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	Completed By	Who Uses and Why	Report Flow
BARANGAY HEALTH STATION **Authorized Stock Level (ASL):** 3 months **Order/Delivery Interval:** Monthly **Order/Delivery Process:** The midwife "tops up" or replenishes her stock once a month at a regular staff meeting at the Rural Health Unit (RHU). She uses a BHS Monthly Order Worksheet to calculate the quantity to order. On the ordering day the midwife physically counts the stock on hand and enters it on her BHS Worksheet. She subtracts the "Stock on Hand" from the "ASL" to arrive at the "Quantity Required." The midwife also enters on the BHS Worksheet the quantity "Dispensed to Users Since Last Order." She calculates this by adding the total quantity of each contraceptive dispensed to clients and Barangay Health Workers (BHW) in her Dispensed to User Record. When placing her monthly order at the RHU the midwife brings her BHS Worksheet as well as her Dispensed to User Record to validate the "Quantity Required" on the BHS Worksheet. **Other:** The midwife is responsible for storing the contraceptives in a clean, dry, pest-free, safe, well-ventilated storage area and for practicing FEFO—First Expiry, First Out.	Dispensed to User Record BHS Monthly Contraceptive Order Worksheet	BHS Midwife BHS Midwife	Midwife: to record contraceptives dispensed to clients Midwife: to order contraceptives monthly	Retained by Midwife Copy 1 - BHS Midwife CDLMIS file
RURAL HEALTH UNIT, HOSPITAL, NGO **Authorized Stock Level (ASL) :** 6 months **Order/Delivery Interval:** Quarterly **Order/Delivery Process:** The RHUs, Hospitals and NGOs do not place orders for contraceptives. The provincial and city Delivery Teams deliver once a quarter to these facilities. The RHUs role at the time of the delivery is to make available to the Delivery Team all CDLMIS related records, inform the team about any	Contraceptive Order form	LGU Delivery Team	RHU, Hospital and NGO FP Nurse: to know when to place an emergency order RHU, Hospital and NGO	1 copy - Receiving Facility

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	**Completed By**	**Who Uses and Why**	**Report Flow**
"adjustments" to stock since the last delivery, make the stocks available in one place for counting by the Delivery Team, and sign the Contraceptive Order Form (COF) and Requisition and Issue Voucher (RIV) to acknowledge receipt of the goods.	RIV	LGU Delivery Team	FP Nurse: as proof of the quantity delivered	1 copy - Receiving Facility
RURAL HEALTH UNIT, HOSPITAL, NGO* (Continued) **Emergency Ordering:** If at any time in between deliveries from the provincial or city Delivery Teams, the facility's stock level for any item drops below the one month supply level a staff person from the facility must go to the provincial or city health office and place an emergency order. **Supplying BHS Midwives:** The RHU Public Health Nurse ensures that all midwives order contraceptives monthly using the BHS Order Worksheet. In filling a Midwife's order the RHU Nurse reviews the BHS Worksheet for accuracy, validates the "Dispensed to Users" figures by looking at the Midwife's Dispensed to User Record, completes columns 6 and 7 of the BHS Worksheet, and issues the contraceptives to the Midwife. The RHU Nurse then asks the midwife to copy the data from the Midwife's BHS Worksheet onto the RHU nurses copy, and to sign the copy to acknowledge receipt of the contraceptives. Every three months the RHU Nurse re-sets each Midwife's ASLs. **Other:** The RHU Nurse is responsible for storing the contraceptives in a clean, dry, pest free, well-ventilated storage area and for practicing FEFO—First Expiry, First Out. * Hospitals and NGOs do not have BHSs and therefore do not use BHS Order Worksheets	Dispensed to User Record BHS Monthly Contraceptive Order Worksheet	BHS Midwife RHU Nurse (Cols. 6 & 7)	RHU Nurse: looks at the Midwife's Dispensed to User record to validate the "Dispensed to Users" figure on the Midwife's BHS Worksheet RHU Nurse: to fill the Midwife's order and record issues of the contraceptives to the Midwife	Retained by Midwife Copy 2 - Nurse CDLMIS file
PROVINCIAL/CITY HEALTH OFFICE **Authorized Stock Level (ASL):** 6 months **Order/Delivery Interval:** Quarterly **Order/Delivery Process:** DOH central routinely ships	Invoice Receipt	FPS Logistics	PHO/CHO consignee:	1 copy - to

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	**Completed By**	**Who Uses and Why**	**Report Flow**
contraceptives direct to the LGUs on a quarterly basis. The Provincial Health Offices (PHO) and City Health Offices (CHO) do not order contraceptives from DOH central except when it is necessary to place an emergency order.	for Property (IFRP) and Bill of Lading (BL)	Section	signs to acknowledge receipt of goods; proof of quantities received which are entered into chart of accounts and stock cards	PHO/CHO consignee
PROVINCIAL/CITY HEALTH OFFICE (Continued)				
Distribution to RHUs, Hospitals and NGOs: The PHOs/CHOs have Delivery Teams which deliver each quarter to these facilities. The facilities do not place an order. The Delivery Team prior to starting its delivery run uses past records to estimate the quantities required by each facility. The team loads these quantities on the truck for each day's deliveries. Upon arrival at the facility the team questions the staff about any "adjustments" (loss, damage, etc.) to stock, counts the stock on hand, subtracts stock on hand from stock available, and calculates the new average monthly usage for the facility and the new ASL. The team subtracts the stock on hand from the ASL to determine the quantity to deliver or to retrieve. These calculations are made on the Contraceptive Order Form (COF) in 4 copies. When the stocks are delivered or retrieved, the staff at the receiving facility sign the COF and a Requisition and Issue Voucher in four copies to acknowledge receipt of the contraceptives.	Contraceptive Order Form	Delivery Team	Delivery Team: to determine quantity to deliver to RHUs, hospitals and NGOs	Yellow copy - Delivery Team Leader
	RIV	Delivery Team	Delivery Team: as proof of receipt of the contraceptives by the facilities	1 copy - Delivery Team Leader
	BHS Monthly Contraceptive Order Form	BHS Midwife and RHU Nurse	Delivery Team: to validate the RHUs average monthly usage of contraceptives and to monitor whether the midwives are ordering contraceptives every month	Copy 2 - in RHU Nurses CDLMIS File
	CDLMIS Inventory Report	Delivery Team	Delivery Team: as a record of inventory	1 copy - Delivery Team Leader
Submission of Documents to DOH Central and Regional Offices: Upon completion of a round of deliveries the Delivery Team puts any excess stocks off the truck into the bodega and does a physical count of all stocks in the bodega. This information is entered on the CDLMIS Inventory Report. The Delivery Team then sends the original of the Inventory Report, the COFs and the RIVs by courier to DOH Central, and sends a second copy to the Regional Health Office.	SDR and Cover Letter	DOH Central (FPS Logistics Section)	Delivery Team: to check inconsistencies and mathematical errors on COFs; to check the supply status at their warehouse; and to follow up on	1 copy - Delivery Team Leader

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	**Completed By**	**Who Uses and Why**	**Report Flow**
Other: The PHO must receive and properly store the contraceptives sent by DOH Central Office. The PHO also receives the Summary Delivery Report (SDR) printout and cover analysis letter which DOH Central prepares from the PHOs delivery data, and follows up on any issues raised in the cover letter.			problems identified	
REGIONAL HEALTH OFFICE **Authorized Stock Level (ASL):** The RHOs do not receive or store contraceptives under CDLMIS, and therefore do not have an ASL. **Monitoring:** The RHO Family Planning technical staff and the DOH Local Health Board Representatives under each RHO have first line responsibility for monitoring distribution of contraceptives to the facilities within the LGUs by the LGU Delivery Teams. They are also informed in advance when DOH Central Office is shipping contraceptives to their LGUs.	Invoice Receipt for Property (IRFP) and Bill of Lading (BL) for deliveries to LGUs from DOH Central	DOH FPS Logistics Section	RHO FP Coordinator: to know the quantities of contraceptives being shipped to the LGUs in the region and to answer queries from the LGUs re pending shipments	Advance copy-to RHO FP Coordinators
	Contraceptive Order Form; RIVs; CDLMIS Inventory Report	LGU Delivery Teams	RHO FP Coordinator: to know that LGUs have made deliveries to facilities; to know the stock levels at the PHO/CHO bodega and at the service outlets	1 Copy of each of these three documents is sent to the RHO by the LGU Delivery Team at the same time the originals are sent to DOH FPS Logistics Section
	SDR printout and analysis cover letter	DOH FPS Logistics Section	RHO FP & LGAMS Coordinators: to know the supply status at the PHO/CHO bodegas and at the service facilities; to follow up on problems identified in the cover letter; to direct DOH Local Health Board Representatives to follow	

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	Completed By	Who Uses and Why	Report Flow
			up on problems identified; to check on performance	
DOH CENTRAL **Authorized Stock Level (ASL):** 6 months **Order/Delivery Interval:** Quarterly				
Order/Delivery Process: Contraceptive donors are requested by the DOH to produce and deliver commodities every quarter to the DOH so that the commodities will have as much remaining shelf life as possible when they reach the public, and so the national contraceptive warehouse does not become congested.	Packing List, Bill of Lading and Commercial Invoice	Donor Agency's Freight Forwarder	DOH PLS: for Customs clearance; for entering into chart of accounts; for entering onto stock cards	DOH PLS
Deliveries to Provinces and Cities: The FPS Logistics Section receives by courier from each province and city at the end of each LGU quarterly delivery round a package containing the CDLMIS Inventory Report from the PHO/CHO warehouse plus the COFs and RIVs from all service facilities receiving deliveries in that round. These data are encoded and analyzed by the Logistics Section. This results in a Summary Delivery Report (SDR) printout and an analysis cover letter which is sent to the LGU FP Coordinator and to the RHO FP Coordinator for further analysis and follow up of identified problems. The consumption data from the SDR printouts are used to establish the current Average Monthly Usage (AMU) and Authorized Stock Level (ASL) for the LGU for each contraceptive. The stock on hand data are subtracted from the ASL to determine the quantity of each contraceptive to ship to the LGU. Once these quantities are entered in the computer the computer generates the IRFPs and BLs required to send shipments to the LGUs. PLS processes these documents and schedules commodity shipments. DOH's contracted freight hauler then delivers contraceptives direct to the provinces and cities under "Package 3" of the DOH brokerage and hauling services contracts. The consolidated SDR figures on total annual consumption and on stock on hand nationwide at the end of the year are used in determining quantities of contraceptive supplies to request from the donors.	CDLMIS Inventory Report; Contraceptive Order Form; RIVs Summary Delivery Report and analysis cover letter IRFPs and BLs	LGU Delivery Team FPS Logistics Section FPS Logistics Section	FPS Logistics Section: for data encoding FPS Logistics Section: to determine quarterly LGU shipments; to identify problems needing follow up by RHO and PHO FP Coordinators and DOH LHB Representatives; to determine quantities to order from the donors PLS: to direct Freight Forwarder on quantities to ship; to transfer commodities from DOH to the LGUs; FPS Logistics Section: to monitor the performance of the Freight Forwarder; DOH Accounting: for payment to forwarder	FPS Logistics Section files 1 copy - Retained by Freight Forwarder 1 copy - DOH Accounting 1 copy - PLS 1 copy - FPS Logistics Section

CONTRACEPTIVE DISTRIBUTION SYSTEM	LOGISTICS MANAGEMENT INFORMATION SYSTEM			
	Form/Report	Completed By	Who Uses and Why	Report Flow
This database from the consolidated SDRs is also used to produce various reports for program managers, e.g., number and percent of facilities with stockouts, with less than one month supply, etc.				

Appendix D.
Contact Persons

USAID/Philippines	
Dr. C. Carpenter-Yaman	Chief, Office of Population, Health and Nutrition
Mr. P. Balakrishnan	Population Development Officer
Mr. R. Glori	Project Management Specialist
JSI/FPLM/Philippines	
Mr. D. Alt	Resident Advisor
Mr. J. Amable	Logistics Program Coordinator
Dr. R. Frogoso	Logistics Program Officer
Dr. M. Balahadia	Logistics Program Officer
Ms. T. Nepomuceno	Logistics Program Officer
Mr. C. Arriola	Logistics Program Officer
Mr. M. Padilla	Logistics Program Officer
Mr. S. Codoniz	MIS Advisor
Other Agencies	
Dr. A. Soriano	Technical Advisor for Health/FH/HIV-AIDS, CARE
Dr. B. Alano	President, Center for Economic Policy Research
Philippines DOH/Central Level	
Dr. R. Infantado	Assistant Secretary
Mr. J. Barcena	Head, FPS Logistics Section
Mr. F. Dela Cruz	CDLMIS Database Operations Manager
Ms. L. Daga	Chief of Training Section
Dr. L. Roquero	Director, Family Planning Service

Dr. J. Aricheta	Chief, Monitoring and Evaluation Division
Dr. J. Ilagan	Head, MIS Section
Dr. D. Capuchino	Service Delivery Head
Ms. A. Relle	Human Resources Management Officer
Ms. V. Paner	Chief of Training Division
Dr. A. Anden	Assistant, LGAMS
Mr. J. Ramos	Officer in Charge of Materials Management Division, Logistics Services
Philippines DOH/Region 3/Bulacan Province	
Dr. J. Galeon	Provincial Health Officer I/DOH Representative
Dr. V. Banzon	Provincial Health Officer
Ms. C. Pascual	Rural Health Unit II, Hagonoy
Dr. M.C. Antonino	Municipal Health Officer, Pulilan II
Ms. M. Doliente	Nurse, Plaridel I
Ms. D. Reyes	Midwife, Sn Isidro, Hagonoy
Ms. C. Tiglao	Midwife, Longos, Pulilan II
Ms. E. Cruz	Nurse, Rural Health Unit, Pulilan II
Ms. D. Lumbo	DOH Representative, Pulilan II
Ms. T. Reyes	Midwife, Poblacion, Plaridel I
Dr. J. Gomez	DOH Representative
Ms. F. Villanueva	Delivery Team Member
Philippines DOH/Region 3/Pampanga Province	
Dr. C. Baltazar	Provincial Health Officer
Dr. E. Abcede	Chief, Technical Division, Regional Health Office
Ms. S. Pangcuangco	Population Officer, Delivery Team
Ms. R. Antonio	Population Program Officer III
Ms. L. Sanchez	Population Program Worker I, Delivery Team Leader

Mr. B. Rojas	Population Officer
Mr. T. Quiambao	Provincial Administrative Officer
Ms. M.E. Camiling	Midwife, Dau Main Health Center
Dr. N. Atienza	Dau Main Health Center
Philippines DOH/Region 6/Iloilo City	
Ms. A.M. Garfin	Regional National Tuberculosis Program Coordinator
Dr. V. Gendrala	Regional LGAMS Coordinator
Dr. L. Naragdao	Regional Family Planning Coordinator
Ms. M.J. Dichosa	Regional Health Education and Promotion Officer
Dr. S.G. Chua	Chief, Technical Division
Philippines DOH/Region 6/Negros Occidental Province	
Ms. E.G. Rambuyon	Provincial National Tuberculosis Program Coordinator
Ms. M.E. Martinez	Supply Officer I
Ms. N.G. Agreda	Administration Officer III
Ms. A.N. Matti	NUT Program Coordinator
Dr. M.J.J. Bersabe	Medical Specialists IV/Provincial DOH Representative
Dr.J. Gasendo-Fama	Medical Officer IV/Chief, Technical Services
Ms. M. Fuentebajia	Family Planning Coordinator and Delivery Team Leader
Ms. L.A. Verdeprado	Midwife IV, Delivery Team Member
Ms. M. Salmingo	Nutrition Dietician
Ms. A. De la Cruz	Rural Health Midwife, Maao BHS
Ms. S.M. Celiz	Public Health Nurse I, Bago City Health Office
Ms. P. Garcia	Public Health Nurse, Mansilingan Health Center
Dr. E. Estrella	Rural Health Physician, Mansilingan Health Center
Dr. J. Aritao	Chief Health Officer
Philippines DOH/Region 6/Bacolod City	

Mrs. A. Tejario	City Population Officer
Dr. D. Arisola	MCH Division Chief
Mrs. N. Martinez	Family Planning Coordinator
Mrs. S. Ramas	Control of Diarrheal Diseases Coordinat
Mrs. S. Gelicanao	Control of Acute Respiratory Infection Coordinator
Ms. M. Ibalobar	Provincial Population Officer III
Mrs. G.F. Lozada	Provincial Population Officer IV
Dr. S. Brinas	Rural Health Physician, Abes City Health Center
Ms. R. Bahol	Nurse, Abes City Health Center
Ms. H. Calaling	Nurse, Abes City Health Center

Appendix E.
Documents Reviewed

National Contraceptive Inventory 1991 (March 1991)

All quarterly reports from March 1991 to October 1997

FPLM II PIO/T/ contract

Philippine Country Strategic and Evaluation Plan (FPLM III)

CARE project documents

Training Impact Evaluation

Evaluation of Region 6 EDD Pilot

Composite Indicators for Contraceptive Logistics Management scores from December 1995: Performance and Sustainability

UNFPA Contraceptive Needs Assessment

Monthly Progress Reports to National Services Component Manager

LPP and IFPMHP Logistics Benchmark Certifications

LGEDDS Proposal

Tony Barone Report

CDLMIS manual and forms

Copy of FPS letter to USAID (with attachment) regarding the institutionalization strategy

Appendix F.

Field Visit Notes for Regions 3 and 6

Region 3

Region 3 has six provinces and four cities; only four provinces are LPP-funded. Densely populated, Region 3 is one of the largest regions in the country and efficiently manages the CDLMIS. The efficiency could stem from the region's proximity to Manila, good communication channels, and good relations with the logistics program officer (JSI/FPLM Philippines) in charge of the logistics project.

Bulacan Province

The Bulacan Province has 24 municipalities, 58 RHUs, and 560 BHSs. On December 11, 1997, visits were made to 4 RHUs, 3 BHSs, and provincial and regional representatives.

All interviewees were long-term DOH employees (serving from 5 to 19 years) and most remember the pre-CDLMIS times. They reported that the deliveries of commodities made under the previous family planning system were allocated based on population density and did not take into account the number of actual users. The result was extensive wastage due to expiry.

In addition, staff showed a lack of respect for standard procedures. Expired stock remained at the facilities, records were outdated or nonexistent, and there was little or no monitoring of system performance. Storage facilities were poor, unsecured, and unsafe, and suffered from inadequate temperature control and rat infestation.

With the start of the CDLMIS, procedures were put in place to address all logistics functions, from ordering contraceptives in the amounts required and recording dispensed-to-user data to transferring overstocks to other facilities within the province, thereby reducing waste and maximizing contraceptive distribution and use. Good storage practices are now usually followed. The stores visited at the provincial level were clean and secure, although their organization could be improved. They followed first-to-expire, first-out storage procedures and managed the contraceptive pipeline under ASL principles.

All interviewees had had at least one to four days of CDLMIS training, and all could fill out the forms correctly and calculate the amounts required for delivery. The requisition and issue voucher (RIV) was found attached to the COF in all instances and matched the quantities delivered.

Two-thirds of all facilities visited were appropriately stocked with contraceptive commodities (one to three months of supply). No emergency orders had been written. In facilities that administer Depo-Provera , the drug was in short supply because of a strong shift of Lo-Gentrol users to injectables. Other facilities either had very few Depo-Provera acceptors or did not offer injectables because staff had not been trained. In two out of seven facilities, clients wanting injectables were referred to the hospital. IUDs were not inserted at four of the facilities visited, making Cu T 380A the least popular used method in the province.

Overall, Lo-Gentrol continues to be the most popular contraceptive, representing two-thirds of the method mix at RHUs and approximately three-quarters at BHSs. Condoms make up one-quarter of the method mix at the BHS level and about one-third at RHUs.

Staff at facilities offering Depo-Provera expressed concern about their short supply. Others were concerned about the lack of a budget allocation for printing the CDLMIS forms. Such a situation imposes a costly personal burden on the nurses and midwives; they often have to assume the cost because they are responsible for obtaining and filling out their forms in an accurate and timely way.

Pampanga Province

Two RHUs, one BHS, and the provincial and regional representatives in the Pampanga Province were visited on December 12, 1997.

This province showed the same trends as Bulacan, with a few differences. Interviewees had been working in family planning for at least five years, had had at least one day of CDLMIS training and, in general, and were able to fill out the forms correctly and keep them up to date. In one instance, the COF was filled out incorrectly (it was based on issues data rather than on dispensed-to-user data), inflating the average monthly use (AMU) for Lo-Gentrol by 100 percent. In addition, the RIV was not attached to the form even though a delivery had been made.

The provincial warehouse was disorganized, with no aisle space, and the expiry dates were not labeled adequately. The damaged contraceptives were not separated from the products in use. Natural causes, either floods or the Mount Pinatubo eruption had spoiled some stock. (The eruption caused many problems in the management of the supply chain.)

The ASL was not followed strictly because the delivery team had to allow for bad weather conditions. Nevertheless, the two RHUs visited were overstocked on condoms and IUDs and understocked on Lo-Gentrol and Depo-Provera. The BHS visited had less than 1 month of Depo-Provera. Although Depo-Provera only represents 15 percent of the method mix, it is the second most popular method at Dau Main Health Center (AMU of 300 vials). At the time of the visit, they had less than one month's supply (0.8) because the last delivery did not provide the quantity requested.

The main complaint of those interviewed was that, due to a Depo-Provera shortage, the province had to place a number of emergency orders this year; supply is not meeting the demand of users. They would like to see orders delivered in full.

Other problems were related to the poor accessibility of BHSs and RHUs during bad weather and the unavailability of the nurse at the RHU, which necessitated a return trip at a later date to make a contraceptive delivery.

Region 6

Iloilo City

Staff at the RHO, visited on Wednesday, December 10, stated that, prior to the introduction of CDLMIS in Region 6 where EDD had been pilot-tested, there were many problems: for example, staff had no training and many stockouts occurred. Everything is working well now and, any problems can be identified from the information on the EDD and CDLMIS reports. For example, they can calculate the ASL more systematically, identify an overstock problem, intervene, and move stocks elsewhere. At the moment, they have some problems with stockouts of IUDs and Depo-Provera in some isolated areas, but they have already made efforts to solve these problems, such as ensuring certain sites receive an emergency or special delivery. Reports were received regularly from all LGUs in the region and, as a result, they could provide a contraceptive mix for Region 6. LGUs that do not have LPP status may have more problems delivering commodities, as there is less transportation available to them. For the delivery teams in those areas, timely deliveries are dependent on the willingness of local officials to help with the program.

Negros Occidental Province

The Negros Occidental Provincial Health Office, also part of the EDD test region, was visited on December 11. Its representatives unanimously agreed that CDLMIS, and now EDD, had improved stocks of contraceptives and essential drugs. Their facilities were assured of stocks, and its six-month ASL means that no stockouts of any contraceptives have occurred in a long time. They were confident that stockouts would not occur in the future. The delivery teams ensured regular and adequate supplies, including tuberculosis drugs, which previously had massive stockouts. With close monitoring and use of standard forms, provincial health office managers have the information for management decisions. This provincial office had just forwarded reports for all facilities supplied by the LGU to the DOH at the central level.

With both logistics systems in place, staff could easily identify the training needed. Using the DOH representatives to train and orient field personnel was working well, possibly because all were physicians or nurses. (In other places, they may be dentists or nutritionists and may be lacking a background in family planning and essential drugs.)

To keep traveling expenses from posing a barrier to regular deliveries, staff have established an interim store in Southern Negros, which is closer than the provincial office. Since the schedule was so tight and these supplies had to be delivered to other facilities while transport was available, there was no time left to conduct monitoring.

The question of LPP funding was also raised. Each province has an LPP coordinator, a setup that works well if the coordinator is in the Provincial Health Office where the LPP-funded vehicle is available for delivery teams. In other situations, staff can commandeer the available transport for other uses.

Adherence to CDLMIS protocols was found in all RHUs and BHSs visited. For instance, all worksheets and paperwork were in order at the Maao BHS. The midwife was trained in all methods and had been trained by the nurse at Bago City Health Office in the use of the BHS worksheet. Stock was well kept and all calculations were correct. Condoms were under stocked (only 0.52 months of supply), but the other products were within limits. The midwife reported she would be getting new stock in a few days.

The dispensing protocol was irregular. Sometimes the nurse would dispense 12, 24, or 36 condoms at one time depending on whether the client needed a one, two, or three-month supply. Then she might not have any condom clients for a month and, as a result, the BHS worksheet might show a seemingly erratic distribution of methods (for example, 160 condoms dispensed last month and none this month). No problems were found with either delivery or supply and, in general, the system was functioning well.

Bacolod City

At the time of the visit on December 12, Bacolod City LGU was delivering supplies to 49 RHUs and BHSs, including 19 NGO facilities. Doctors may alternate clinic visits. A lack of tuberculosis drugs for two years caused some problems. There were some problems with Depo-Provera separation (sometimes only 6 mg could be injected instead of 10 mg) and with severely tarnished IUDs. Because of the number of RHUs and BHSs receiving deliveries, monitoring and evaluation was carried out at the time of delivery, allowing problems to be corrected as the delivery teams were distributing the product.

The warehouse/storeroom was not large enough. The space set aside for essential drugs was filled with old, broken machinery, files, boxes, and obsolete equipment. None could be disposed of because of the usual civil service accountability regulations. A stack of tires outside the family planning office, for

example, could not be removed. However, the LGU has promised to provide extra space very soon so that essential drugs can be stored in a better place.

Staff would like more drug products added to the distribution system. The main problem is obtaining the drugs from the DOH centrally; drugs are being shipped to the regions, as in the past, instead of straight to the LGUs. Cotrimoxazole was overstocked in many places because providers preferred it in suspension form rather than as tablets.

At this LGU, it was also possible to interview the Sexual Health Clinic staff. They explained they were working with approximately 400 commercial sex workers (CSW) in the city, seeing 70 to 90 of them a day, and distributing approximately 25 condoms per week to each sex worker. In total, this represents approximately 40,000 condoms distributed per month to the CSWs.

At one facility visited, there were no Depo-Provera or IUD clients. Staff had developed their own tracking record sheet for recording stock on hand and stock being dispensed. No BHS worksheet had been completed because the delivery team determined the stock levels. At other facilities visited in Bacolod, all records and logistics information were correct. All stock was stored in a locked filing cabinet provided with part of the LPP funds by Bacolod City to protect the essential drugs and contraceptives. First-to-expire, first-out storage procedures were observed everywhere, facilities were clean and well maintained, and the staff generally took pride in their work.

Appendix G.

Composite Indicators for Contraceptive Logistics Management

The EVALUATION Project

The Family Planning Logistics Management Project (FPLM)
(John Snow, Inc., and the Centers for Disease Control)

Version April 1999

Guidelines for Scoring the Composite Indicators for Commodities and Logistics

Background and Intended Use

The Commodities and Logistics Working Group, organized under The EVALUATION Project, has developed two types of indicators for evaluating the performance of logistics systems. One type consists of individual indicators, which can be meaningfully measured. The second type involves composite indexes, which encompass all key dimensions of a logistics system, including both quantitative and qualitative elements. The two types of indicators were designed to be complementary. The composite measures were developed because the individual indicators alone did not provide a complete picture of the logistics system. The composite indicators are intended to evaluate the overall performance of a logistics system.

There are two composite indicators: the Performance Indicator and the Sustainability Indicator. One measures the performance of the logistics system while the other measures the degree to which the system functions independently of outside assistance. These two indicators contain the same items, but are scored in relation to these two different purposes.

Although the composite indicators could be applied to various logistics systems and at various levels of the system, their primary application is intended to be at the national level for a particular logistics system. Therefore, when completing the scoring form, please note which system and at what level you conduct your evaluation, e.g., national MOH system, regional IPPF system, social marketing system for oral contraceptives and condoms, and so forth.

The primary use of these indicators will be to evaluate performance of logistics systems at different points in time in order to show how program efforts are being translated into improved systems. It is not intended to serve as a detailed diagnostic tool.

Scoring Guidelines

These scoring guidelines are intended for logistics advisors who are well acquainted with the operation of logistics systems. Proper use of these indicators requires a number of judgments, such as whether procedures are “proper” or facilities are “adequate.” These judgements should be made by people with a good understanding of logistics procedures and guidelines.

Both composite indicators are composed of 23 individual items grouped into eight elements. The Performance Indicator addresses the question: "How well is the logistics system functioning?" Each item should be scored on either a five-point (0 to 4) or three-point (0 to 2) scale, as marked on the scoring form. A score of zero means the complete lack of existence of the characteristic or function. A top score of four or two means all the characteristics are present and the function is performed well at all levels of the system. If a function is not performed by a particular system being scored, it should receive a score of 0.

The Sustainability Indicator addresses the question "How independent is the system from donor support?" All elements are scored on the same 0-4 or 0-2 point scales. In this case, however, the top scores are for functions that are carried out without any outside assistance. Zero scores indicate that the function is entirely dependent on outside assistance. The degree of outside assistance is the only criteria for assigning the score. Thus if a particular system does a poor job of forecasting, but receives no outside help, it should receive a top score on the Sustainability Indicator, even though it will receive a low score on the Performance Indicator.

It is important for the scorer to record the rationale for each score as well as any important notes or caveats pertaining to the score under the comment section. Without these comments it will be very difficult to assess changes over time, especially when two different scorers are involved.

Some indicators contain several characteristics, such as adequacy of storage capacity and conditions, which include water leaks, security, stacking procedures, etc. Individual indicators were not developed for each aspect; instead, the evaluator must make an attempt to include all these factors in the score.

An additional consideration (if scoring is being done at the national level) is that scores should encompass judgments made about all levels of the system--national to service delivery point levels. Impressionistic judgments are acceptable and will be more useful if reasons are carefully annotated under the comment section. Even if you do not know anything about a particular item, you should make your best guess, since a blank or zero score will be interpreted as a lack of that function or complete reliance on outside assistance.

Scoring should be done on an absolute as opposed to a relative basis. This means that programs should be scored on the same basis regardless of the stage of development of their family planning program or the situation in the country.

Countries in which FPLM is working have all been assessed through the CIs at the beginning of the project (FPLM III) from September 1995 onwards so that at least one "baseline" score is available. The systems for each country will duly be re-assessed at least at "mid-term" and "final" stages of the project so that some indication of progress can be made.

There are some weaknesses inherent in the scoring of the CI for different systems. First the CI assessments are fairly subjective - they are judgements based on the extent of the knowledge of the scorer. It is difficult for someone to rank each component of the system without in-depth knowledge of that system. On the other hand those who are working with the system in a very close way, particularly those who are in charge of the systems, may have a biased view of the system.

In order to ameliorate the problems above, at least two measures may be taken. The first is to get as many people as possible to independently score the 8 elements and 23 sub-elements of the system in order to generate a range of values. However technically, it is difficult to aggregate these scores as they are *ordinal* data and therefore may not be averaged across scorers.

A second and better solution is to arrange groups of scorers together so that they can discuss the situation and then come up with a score for each item. This has the effect of consensus - especially if the groups are equally matched and comprise no more than three or four people in each group.

The CIs should be used as a learning mechanism and a group consolidation tool - as well as an exercise in obtaining some descriptive data. Indeed one of the advantages to using the small group process is that the various components of the management and logistics system get fully discussed. From previous experience (Philippines, Morocco), and research (Stover et al), a nominal group technique method for scoring the CI's is considered preferable.

Nominal Group Method for Scoring CI's

This process is a kind of "nominal group technique" whereby first the smaller groups and then the larger group puts effort into, and then owns the results coming out of the process. In the course of doing so discussion about the wider issues takes place, learning takes place and the participants become more knowledgeable about the contraceptive distribution and logistics management system in their country.

The following steps are given as a guideline:

1. Identify all the relevant personnel who know enough about the system to be able to assess it (maximum 15-20 - minimum 6)

2. Make administrative arrangements for a one day exercise (hotel or conference room- preferably away from the place of work of the scorers, lunch, snacks etc...)

3. Split the large group into smaller groups (groups of three work best) with as equal a knowledge base as possible in each of the groups.

4. Facilitator (FPLM advisor) introduces the day in terms of what is to be achieved and emphasizing what is required is an honest reflection of the system being assessed. Clarification of the CI and the scoring mechanisms should also be done at this time.

5. The first indicator (LMIS) should then be discussed by each of the groups for a set amount of time. The LMIS indicator has four sub-elements to separately score for Performance and Sustainability. Thus this first element will take time until each of the small groups has achieved an agreeable way of conducting discussion within their separate groups. Thus if 10 minutes are given over for each of the sub-elements and 5 minutes override, then this first element could take 45 minutes.

6. When all the small groups have finalized their scores, the facilitator needs to go round collecting the scores for each small group. This may then be followed by a joint group discussion on the scores where there are differences of opinion. The aim is to come up with an agreed consensus score for Performance and Sustainability for each of the sub-elements in 15 minutes.

7. Repeat steps 5 and 6 for each of the elements in the Composite Indicators. Some of these with only one or two sub-elements such as Policy or Forecasting may take little time, whereas others like Distribution, which has five sub-elements, may take a lot longer. An approximate time guide for each of the elements, in minutes for a group of 12 divided into 4 small groups is: LMIS (60);

Forecasting (30); Obtaining Supplies/Procurement (30); Warehousing & Storage (50); Distribution (60); Organization & Staffing (50); Policy (15); Adaptability (15).

8. After completing all the scores and obtained a consensus for each sub-element, the resultant total overall scores may be compared to the baseline scores to see if there has been improvement or otherwise in a group discussion. This may take a further 20 minutes.

As can be seen from the above, the process outlined is not one which is quick - it is necessarily an all-day affair which serves the purpose of obtaining the best consensus score from people involved in the management of logistics and commodities for a country. More than this, it serves as a forum for identifying the strengths and weaknesses of a system from which can be drawn lessons learned and strategies to address deficiencies in the system. In turn these can feed into the CSEP for a country for future activities.

Aggregating Scores

Once individual scores have been assigned for each item, Word will automatically calculate the overall composite score for each indicator.

To enter individual item scores for each of the eight elements beginning on p. 5, place the insertion point in the space above the potential scores [i.e., "(0-4)"] and enter the given score. Moving the insertion point out of the cell will prompt Word to automatically calculate the entire document--i.e., it will sum the columns under the column heads (i.e., *Performance* or *Sustainability*) and will complete both worksheets.

WORKSHEET FOR CALCULATING THE PERFORMANCE INDICATOR

Element	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
1. LMIS		12		17	
2. Forecasting		8		11	
3. Procurement		8		17	
4. Warehousing and Storage		12		17	
5. Distribution		18		17	
6. Organization and Staffing		14		11	
7. Policy		4		5	
8. Adaptability		4		5	
TOTAL OVERALL SCORE					

WORKSHEET FOR CALCULATING THE SUSTAINABILITY INDICATOR

Element	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
1. LMIS		12		17	
2. Forecasting		8		11	
3. Procurement		8		17	
4. Warehousing and Storage		12		17	
5. Distribution		18		17	
6. Organization and Staffing		14		11	
7. Policy		4		5	
8. Adaptability		4		5	
TOTAL OVERALL SCORE					

Scores arrived at using this procedure will range from a high of 100 to a low of 0.

COMPOSITE INDICATOR FOR COMMODITIES AND LOGISTICS SCORING FORM

Name of Scorer_____ **Country**:_____ **Date**:_____ (MM/DD/YY)

Name of Program Scored:_____

Type of Program: Government / IPPF-Affil. / NGO / Social Marketing / Pvt. Commercial
Other (specify):_____ (***circle one***)

Baseline_____Midterm_____Final_____Other_____ **Replacement Scores**: YES NO

Level Scored: Whole System / Central Only / Regional Only / District Only / Local (SDP) (***circle one***)
If Regional or District or Local, please specify location/name: _____

General Notes:

Performance	Sustainability	1. Logistics Management Information System (LMIS)
(0-4)	(0-4)	● **Program has basic elements of LMIS system**. LMIS contains beginning inventory balance, supplies received, supplies issued, ending inventory balance, and system losses. LMIS system contains contraceptives component, keeps appropriate records throughout the system for contraceptives, and is documented in writing. Comments:
(0-4)	(0-4)	● **LMIS information is used in management decision making**. Data are used for continuous monitoring of supply situation as well as periodic forecasting and ordering. Comments:
(0-2)	(0-2)	● **LMIS information is fed back to all lower levels in the distribution system.** Summary data are periodically provided to regional and subregional distribution stations. Comments:
(0-2)	(0-2)	● **Commodities data are validated by cross-checking with other data sources.** Commodities data are periodically cross-checked against supplies received, service statistics, survey data, and field audit data. Comments:

Performance	Sustainability	2. Forecasting
(0-4)	(0-4)	● **Periodic forecasts of consumption are prepared, updated, and validated.** Forecasts of consumption are properly prepared for each program, method, and brand. Both short-term (e.g., annual) and longer-term (e.g., three year) forecasts are prepared in accordance with program needs of local budgeting and procurement cycles. Forecasts are prepared and updated using most recent and appropriate data. Forecasts take into account programmatic plans (i.e., expansion of service outlets, training, AIDS advertising, etc.). Forecasts are validated by comparing forecasted consumption with reported consumption for past years. Comments:
(0-4)	(0-4)	● **Forecasts are incorporated into cost analysis and budgetary planning.** Costs and budgets include not only goods, but also warehousing and transport costs. Comments:

Performance	Sustainability	3. Obtaining Supplies/Procurement
(0-4)	(0-4)	● **Consumption forecasts are used to determine short-term procurement plans.** Procurement forecasts take into account inventory levels, coordination of suppliers/donors, shipment and handling schedules, and anticipated changes in program activity. Program actively monitors/manages coordination among suppliers/donors. Program addresses need to maintain continuity of brands (particularly hormonal formulations). Comments:
(0-4)	(0-4)	● **Right amount of contraceptives are obtained in appropriate time frame.** Program knows and complies with procedures and time frames for ordering commodities from suppliers and donors, including trade, regulatory, and currency restrictions. Comments:

Performance	Sustainability	4. Warehousing and Storage
(0-4)	(0-4)	● **Adequacy of storage capacity and conditions.** Storage capacity is large enough for present needs and program has plans for meeting needs into the foreseeable future (i.e., five years hence). Storage conditions meet acceptable standards, including standards for cleanliness, orderliness, arrangement and labeling of supplies to facilitate FEFO system, stacking of supplies, security, ventilation, light, water leaks, fire safety, insect precautions, and organization of information files. Program has written guidelines for storage and handling of contraceptives. Comments:
(0-2)	(0-2)	● **Conducts at least one physical inventory of contraceptives per year at each warehouse.** Comments:
(0-2)	(0-2)	● **Knows and complies with standards for maintaining product quality.** Program has procedures for ensuring products received meet standards, visual inspection of goods take place, products can be sampled and tested for quality, and unfit and expired products are destroyed. Has procedure for capturing client complaints regarding product quality. Comments:
(0-4)	(0-4)	● **Issues stock according to first expiry/first out (FEFO) inventory control procedures.** Comments:

Performance	Sustainability	5. Distribution
(0-4)	(0-4)	● **Has appropriate distribution system and schedule for stocking each level.** Procedures should specify what type of distribution system (i.e., min/ max, topping up, etc.) is being used. System should have a documented distribution schedule. Comments:
(0-4)	(0-4)	● **Each level is stocked adequately.** Each level of the distribution system is maintaining inventories in accordance with guidelines specified in plan. Comments:
(0-4)	(0-4)	● **Minimal stockouts have been experienced during the previous year.** Seriousness of stockouts can be assessed by considering the relative importance of stocking out of the method/brand, the level or location of the stockouts, and duration of stockouts. Comments:
(0-2)	(0-2)	● **Has a system for tracking and documenting system losses.** Has a system for tracking system losses. Non-routine losses and large amounts of unaccounted for supplies are investigated. Comments:
(0-4)	(0-4)	● **Has adequate transportation system for moving supplies.** Not only do adequate transportation resources exist and are being utilized effectively, but vehicles are being adequately maintained. Comments:

Performance	Sustainability	6. Organization and Staffing
(0-4)	(0-4)	● **An appropriate logistics unit exists; the unit has adequate resources; and the Logistics Officer-in-Charge has adequate authority.** The logistics unit has responsibility for managing the contraceptive logistics system and has adequate resources to serve the national family planning program. The Logistics Officer-in-Charge is a dedicated position (i.e., he shares no other responsibilities) and has adequate authority, (i.e., is equivalent to other functional unit heads). Comments:
(0-4)	(0-4)	● **Effective supervision is maintained at all levels and written policies and procedures exist.** Supervision occurs routinely. A written manual exists to ensure that the logistics system is institutionalized and would be able to survive a turnover of staff. Comments:
(0-2)	(0-2)	● **Has a logistics training plan and an adequate number of active personnel have been trained in logistics.** Comments:
(0-4)	(0-4)	● **Has sufficient personnel performing appropriate logistics activities.** Comments:

Performance	**Sustainability**	**7. Policy**
(0-4)	(0-4)	● **Logistics information is provided to appropriate policymakers.** Logistics information is provided to appropriate inter- and extra-governmental decision makers (e.g., Ministry of Health, Ministry of Finance, UNFPA, and USAID) regarding program goals and logistics planning. Comments:
Performance	**Sustainability**	**8. Adaptability**
(0-4)	(0-4)	● **Entire logistics system has ability to successfully adapt to changes**. Logistics system is responsive and can adapt to changing situations. Capability exists to obtain necessary resources, either internally or externally, to supply growing demand. Comments:

Table G-1. Summary of Baseline Composite Indicator Scores, December 1995

ELEMENT	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
PERFORMANCE					
1. LMIS	9.0	12	0.75	17	12.75
2. Forecasting	7.0	8	0.88	11	9.63
3. Procurement	8.0	8	0.88	17	14.88
4. Warehousing and storage	8.0	12	0.67	17	11.33
5. Distribution	14.0	18	0.78	17	13.22
6. Organization and staffing	12.0	14	0.86	11	9.43
7. Policy	3.0	4	0.75	5	3.75
8. Adaptability	3.0	4	0.75	5	3.75
TOTAL PERFORMANCE SCORE					78.73
SUSTAINABILITY					
1. LMIS	1.0	12	0.08	17	1.42
2. Forecasting	1.0	8	0.13	11	1.38
3. Procurement	0.0	8	0.00	17	0.00
4. Warehousing and storage	7.0	12	0.58	17	9.92
5. Distribution	6.0	18	0.33	17	5.67
6. Organization and staffing	3.0	14	0.21	11	2.36
7. Policy	1.0	4	0.25	5	1.25
8. Adaptability	2.0	4	0.50	5	2.50
TOTAL SUSTAINABILITY SCORE					24.48

NOTE: The results from this type of procedure presented in Table G-1 can range from a low of 0 to a high of 100.

Table G-2. Summary of Mid-term Composite Indicator Scores, Groups 1–3, December 1997

ELEMENT	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
PERFORMANCE					
1. LMIS	9.33	12	0.78	17	13.22
2. Forecasting	7.33	8	0.92	11	10.08
3. Procurement	7.67	8	0.96	17	16.29
4. Warehousing and storage	7.67	12	0.64	17	10.86
5. Distribution	13.67	18	0.76	17	12.91
6. Organization and staffing	11.00	14	0.79	11	8.64
7. Policy	3.33	4	0.83	5	4.17
8. Adaptability	3.00	4	0.75	5	3.75
TOTAL PERFORMANCE SCORE					79.93
SUSTAINABILITY					
1. LMIS	7.67	12	0.64	17	10.86
2. Forecasting	5.67	8	0.71	11	7.79
3. Procurement	4.67	8	0.58	17	9.92
4. Warehousing and storage	9.67	12	0.81	17	13.69
5. Distribution	12.67	18	0.70	17	11.96
6. Organization and staffing	10.33	14	0.74	11	8.12
7. Policy	3.67	4	0.92	5	4.58
8. Adaptability	2.67	4	0.67	5	3.33
TOTAL SUSTAINABILITY SCORE					70.26

NOTE: The numbers in Table G-2 represent the most frequent score used in the composite of individual group scores displayed in Tables G-3, G-4, and G-5. They are not mathematical averages because the group's scores are ordinal and, therefore, preclude the use of fractions. The results from this type of procedure can range from a low of 0 to a high of 100.

Table G-3. Group 1 Scores, December 1997, FPLM/ Philippines representatives

ELEMENT	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
PERFORMANCE					
1. LMIS	9	12	0.75	17	12.75
2. Forecasting	8	8	1.00	11	11.00
3. Procurement	8	8	1.00	17	17.00
4. Warehousing and storage	8	12	0.67	17	11.39
5. Distribution	14	18	0.78	17	13.26
6. Organization and staffing	8	14	0.57	11	6.27
7. Policy	3	4	0.75	5	3.75
8. Adaptability	3	4	0.75	5	3.75
TOTAL PERFORMANCE SCORE					79.17
SUSTAINABILITY					
1. LMIS	6	12	0.50	17	8.50
2. Forecasting	6	8	0.75	11	8.25
3. Procurement	6	8	0.75	17	12.75
4. Warehousing and storage	10	12	0.83	17	14.11
5. Distribution	12	18	0.67	17	11.39
6. Organization and staffing	10	14	0.71	11	7.81
7. Policy	4	4	1.00	5	5.00
8. Adaptability	2	4	0.50	5	2.50
TOTAL SUSTAINABILITY SCORE					70.31

Table G-4. Group 2 Scores, December 1997, DOH representatives plus a USAID representative

ELEMENT	*(1) Actual* Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) Calculated Score Col 3 x Col 4
PERFORMANCE					
1. LMIS	9	12	0.75	17	12.75
2. Forecasting	7	8	0.88	11	9.68
3. Procurement	7	8	0.88	17	14.96
4. Warehousing and storage	8	12	0.67	17	11.39
5. Distribution	14	18	0.78	17	13.26
6. Organization and staffing	13	14	0.93	11	10.23
7. Policy	3	4	0.75	5	3.75
8. Adaptability	3	4	0.75	5	3.75
TOTAL PERFORMANCE SCORE					79.77
SUSTAINABILITY					
1. LMIS	8	12	0.67	17	11.39
2. Forecasting	6	8	0.75	11	8.25
3. Procurement	5	8	0.63	17	10.71
4. Warehousing and storage	7	12	0.58	17	9.86
5. Distribution	14	18	0.78	17	13.26
6. Organization and staffing	11	14	0.79	11	8.69
7. Policy	3	4	0.75	5	3.75
8. Adaptability	3	4	0.75	5	3.75
TOTAL SUSTAINABILITY SCORE					69.66

Table G-5. Group 3 Scores, December 1997, DOH representatives plus a CARE representative

ELEMENT	(1) Actual Score	(2) Potential Score	(3) Fraction of Potential Col 1/Col 2	(4) Weight	(5) **Calculated** Score Col 3 x Col 4
PERFORMANCE					
1. LMIS	10	12	0.83	17	14.11
2. Forecasting	7	8	0.88	11	9.68
3. Procurement	8	8	1.00	17	17.00
4. Warehousing and storage	7	12	0.58	17	9.86
5. Distribution	13	18	0.72	17	12.24
6. Organization and staffing	12	14	0.86	11	9.46
7. Policy	4	4	1.00	5	5.00
8. Adaptability	3	4	0.75	5	3.75
TOTAL PERFORMANCE SCORE					81.10
SUSTAINABILITY					
1. LMIS	9	12	0.75	17	12.75
2. Forecasting	5	8	0.63	11	6.93
3. Procurement	3	8	0.38	17	6.46
4. Warehousing and storage	12	12	1.00	17	17.00
5. Distribution	12	18	0.67	17	11.39
6. Organization and staffing	10	14	0.71	11	7.81
7. Policy	4	4	1.00	5	5.00
8. Adaptability	3	4	0.75	5	3.75
TOTAL SUSTAINABILITY SCORE					71.09

Appendix H.

Institutionalization of the FP Logistics Function in the Family Planning Program – DOH (FPS)

Republic of the Philippines
Department of Health 72-2
OFFICE FOR PUBLIC HEALTH SERVICES
Manila
711-62-35

November 2, 1995

Dr. Carol Carpenter-Yaman
Chief, Office for Population, Health and Nutrition
U.S. Agency for International Development
Ramon Magsaysay Building
Roxas Boulevard, Manila

Dear Dr. Carpenter-Yaman:

The Family Planning Service staff have been discussing in earnest the requirement for the Department of Health to institutionalize the Contraceptive Distribution and Logistics Management Information System (CDLMIS) as quickly as possible. We believe it is possible to fully absorb the system by December 1998.

Major components of the system such as customs clearance of donated contraceptives, shipping of contraceptives to the LGUs, and operation of the logistics management information system can be institutionalized by June of 1996 if the DOH Family Planning Service budget is approved at the requested levels.

The remaining major component of the system is field monitoring and "trouble shooting" the system at the LGU level. It is our plan to use the DOH Regional Field Office Family Planning Coordinators for this function in the short term, and in the longer term to train the DOH retained Local Health Board representatives to monitor CDLMIS implementation at the field level.

With the above stated timetable for institutionalization it should be possible for the DOH to assume responsibility for customs clearance, shipping of contraceptives, data encoding, and field monitoring when the USAID funded CARE support ends in early 1996.

This will be the first step in institutionalizing the CDLMIS according to the plan prepared by the FPS Logistics Section.

The USAID funded assistance from CARE to the DOH has been critical to the successful implementation of the CDLMIS. We wish to thank USAID and CARE for this assistance.

If you have any questions regarding the plan for institutionalizing CDLMIS the FPS staff and I would be happy to discuss them with you.

Thank you for your continued support to the Philippine Family Planning Program.

Very truly yours,

CARMENCITA NORIEGA-REODICA, M.D., M.P.H., CESO II
Undersecretary for Public Health Services

Activity	Presently Handled by	To be Assumed by DOH Beginning					Annual Budgetary Requirement	Comments
		1995	1996	1997	1998	1999		
1. Management of the National Contraceptive Warehouses.	UNFPA/JSI	10/95					No additional requirement	Already included in DOH budget (security, janitorial and forklift maintenance)
2. Clearance of USAID Supplied Contraceptives through Customs and Delivery to National Warehouse	CARE		1/96				P500,000	To be reprogrammed from FPS Medicine budget.
3.Shipping of USAID and UNFPA Supplied Contraceptives to the LGUs.	CARE		1/96				P3,200,000	To be reprogrammed for the FPS Medicines budget so that FP medicines and medical devices are treated the same as FP medicines for sterilization, side effects treatment, etc.
4. Staffing of the FPS Logistics Section. a. First four positions (Section Chief, Database Operations Manager, MIS Advisor and Warehouseman) b. Final four positions (Assistant Section chief and 3 data encoders)	UNFPA/JSI/ CARE	10/95		6/97			Will vary depending on the type and level of positions are finally approved.	Some of these positions are available in FPS and others may be created by collapsing existing vacant positions in the DOH.
5. Operation of the LMIS. a. Database Operations Management b. Data encoding c. System maintenance and revision	JSI/CARE		6/96	6/97	6/98		P200,000	To cover computer and printer maintenance, paper link, toner, mailing supplies and mailing cost.
6. Purchase of System Materials.	CARE/SJSI				1/98		P312,000	COFs, RIVs, BHS Worksheets, Folders, Inventory Forms and Mailing Envelopes.
7. Field Monitoring/Technical Assistance on CDLMIS to LGUs.	JSI/CARE				6/98		To be absorbed in regular monitoring/travel budget.	DOH FPS Service Delivery and other staff, DIRFO FP Coordinators, DOH local health board representatives and LGU FP Coordinator will be trained to monitor CDLMIS.
8. Training in CDLMIS.	JSI/CARE				6/98		P300,000	DOH FPS Core of Trainers, DIRFO FP Coordinators, DOH local health board representatives and LGU FP Coordinators will be trained to do CDLMIS related training. E.g. delivery team training, RHU Staff Training
9. Preparation of Contraceptive Procurement Tables.	JSI				1/98		No requirement	
10. Management of the Entire FP Logistics Function.	JSI/UNFPA/ CARE				6/98		To be absorbed in the regular FPS office supplies and operations budget.	The DOH would be fully in charge of the FPS Logistics Section by June 1998. Technical Assistance would end in December 1998. The USAID Mission if necessary could request short term consultancies from the FPLM III project in 1999 and 2000 to address any issues arising in FP Logistics in the Philippines.

Appendix I.
FPLM Course Announcement

FAMILY PLANNING LOGISTICS MANAGEMENT COURSE

Workshop Goal

The efficient management of contraceptive supplies is imperative in the current environment of increasing demand and limited resources. The FPLM III Project will be offering a comprehensive introductory course in **logistics system design and management** for family planning and AIDS prevention program managers. The goals of the course are to increase participants' understanding of logistics management and contraceptive forecasting, and to make them better able to assess and address the problems they encounter in the logistics systems they manage.

Areas of Learning

During a series of lively, hands-on sessions, participants engage in a range of activities, including simulation, case study, field trip, demonstrations, and exercises, which provide them with the opportunity to increase their knowledge and skills in the following topics:

Logistics Management Information Systems
Assessing Local and National Supply Status
Maximum-Minimum Inventory Control
Storage
Logistics System Assessment
Forecasting Contraceptive Requirements
Forecasting for AIDS Programs
State of the Art Logistics

Most sessions are designed to draw upon participants' previous experience and to encourage participants to share their experiences with each other.

Who Should Attend

Individuals who are responsible for managing, operating or monitoring family planning or AIDS prevention logistics systems at the **national level,** either in the public or private sector. This course is also highly relevant for in-country managers from donor agencies that provide contraceptives.

While this course is conducted in English, interpretation can be arranged in most cases. We can accommodate up to two participants needing interpreters per course.

Trainers

This course is conducted by a core team of FPLM trainers who not only have considerable knowledge of logistics theory, but also have first-hand experience assessing and designing country-specific logistics systems.

Date & Location

The course will be conducted September 21 - October 9, 1998 in Arlington, Virginia. Participants should plan to arrive at least one day before the course begins. Please contact FPLM to reserve a place in the course and for hotel information.

If interested, but unable to attend the September course, the course will be offered again in April 1999. Please contact FPLM to reserve a place in either the September or April course.

Cost

Participants or their sponsoring agencies are responsible for the cost of round-trip transportation to/from Washington, D.C., miscellaneous travel costs, and full per diem in transit and while in Arlington.

USAID- sponsored participants should be funded through Mission PIO/Ps. If Missions intend to submit a Field Support Memorandum of Understanding designated for the JSI/FPLM III Project for technical assistance activities, funds for this course should be included.

As a guideline in calculating these costs, please budget the following:

- Round-trip airfare to/from Washington, D.C.
- Miscellaneous travel costs (visas, airport taxis, etc.): US$ 160 approximately.
- Per diem: US$ 162 per day for 25 days (includes transit, arrival, departure, and weekend days)
- Interpreter (if necessary): US$ 5250

Workshop costs, including instructors, training facility and materials costs, will be covered by the FPLM III Project.

Contact Information

If you would like more information about the course, or would like to nominate a participant for this course, please contact the persons below or return the attached form by fax **no later than August 15, 1998**

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References from past participants are available on request.